THE VA/DOD HEALTH RESOURCES SHARING ACT—PUBLIC LAW 97–174

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

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THE VA/DOD HEALTH RESOURCES SHARING ACT—PUBLIC LAW 97-174

THURSDAY, JUNE 26, 1986

House of Representatives,
Subcommittee on Oversight and Investigations,
Committee on Veterans' Affairs,
Washington, DC.

The subcommittee met, pursuant to call, at 9:30 a.m., in room 334, Cannon House Office Building, Hon. G. V. (Sonny) Montgomery (chairman of the subcommittee) presiding.

Present: Representatives Montgomery, Rowland, Hillis, and Sundquist.

OPENING STATEMENT OF CHAIRMAN MONTGOMERY

Mr. Montgomery. This hearing will come to order.

I have a rather long statement, and I will read through most of it because I think it is necessary, to explain why we are having these hearings today and set the stage for one of the most important hearings I think we will have this year in the committee. Especially for saving money for the taxpayers and providing better medical treatment for the veteran and for the persons in uniform, as well as retirees of the military.

In 1982, during the 97th Congress, I was pleased to cosponsor H.R. 3502, legislation which became a public law. This law is entitled the Veterans' Administration and Department of Defense Health Resources Sharing and Emergency Operations Act.

The purpose of the legislation was to encourage greater sharing of medical resources between the Veterans' Administration and the Department of Defense. It was intended to overcome many obstacles to such sharing that had been identified by the VA, the DOD, and the General Accounting Office. The law also defined within the concept of resource sharing a medical readiness role for the VA for times of war or national emergencies.

The purpose of the hearing today is to review the implementation of this law. There is evidence—in my statement it said some evidence, but there is evidence that the law is fulfilling its intent. At the end of fiscal year 1985, there were 201 sharing agreements in effect. At the end of 1984, only 81 such agreements had been negotiated. That is a 248 percent increase in 1 year, and that sounds to me like a very successful program.

What we will want to know today is what those numbers mean. We will want to explore, for example, whether the Air Force is more active than the other services in this program. And I might say that the Air Force has implemented more of these sharing agreements than the other services.

We want to know whether the increase in agreements reflects mutual participation between the military and VA in planning. Taking advantage of this sharing law as opportunities occur is one thing, and specific planning to share at the higher levels is quite another. And it is in the planning that the greatest results may be found. We want to learn if planning is really done at the local level and the extent of difficulties in assessing costs when negotiating agreements. I don't know whether we say it in the written statement or not, but I want to find out if they have to go to the top, do they have to go to the Secretary of Army, or have to come to Washington to work out these sharing agreements; do they have to go to the Administrator of the VA here in Washington? We ought to know that.

For example, a creative result of the law has been the joint hospital ventures seen in recent agreements between the Air Force and the VA. In Albuquerque, New Mexico, the Air Force will use part of the new VA Hospital to service inpatient needs of Kirtland Air Force Base. Except for some quick actions, this opportunity would have been missed. It seems important to anticipate perhaps more situations like this that I just mentioned.

Another example of the planning aspect is the change in DOD policy regarding medical treatment of military retirees. This could have substantial impact on the demand faced by the VA. We will learn something about this from the Fleet Reserve Association.

The expanded contingency role of the VA in this law is of particular interest to me. As we look at the shortage of medical personnel in the armed services, especially in terms of the number projected in times of war, the necessity for reinforcements becomes clear. I have introduced legislation to address the problem by requiring men and women ages 18 to 46 who are qualified for practice or employment in a health care occupation to register with the Selective Service System. I am disappointed to report today that this amendment was defeated 28 to 17 in the committee. There were some strong feelings opposed to this amendment by some of my colleagues who felt very strongly about it. I felt very strongly the other way. But the American Medical Association played a great part in defeating this registration of medical care personnel with the Selective Service System, they played a very great part in getting this legislation defeated.

It seems also necessary to depend on the over 32,000 beds that can be made available by the VA within 72 hours.

There is one area that has taken on new meaning recently. That is the medical information systems. Today we would like to learn about sharing activity for medical information in terms of development, implementation and day-to-day operations. This is important when considering joint contingency planning for the armed forces during a war or national emergency.

Now, I would like to yield to my close friend, Bud Hillis, the distinguished ranking minority member of the subcommittee, for any remarks that he would like to make at this time.

OPENING STATEMENT OF HON. ELWOOD HILLIS

Mr. HILLIS. Thank you, Mr. Chairman. My remarks will be brief. It is always a pleasure to serve here on this committee with you.

You have mentioned that back in 1982 the committee initiated legislation to encourage more sharing by the VA with the Department of Defense and provide through sharing a readiness capacity for the VA in case of war or national emergy. Today, we want to examine the extent to which the legislation has been implemented.

Preliminary information indicates there has been considerable reluctance by the VA and DOD officials to embrace it as originally intended. However, that reluctance has been overcome, and the program appears to have become a very successful one. There appears to be widespread agreement that a considerable amount of money has been saved through sharing agreements. Hopefully, the amount will increase as more and more opportunities are seen by both the VA and DOD.

I have been particularly impressed with the joint role of the two agencies with respect to the VA medical center in Albuquerque, NM, and that role will be discussed today by witnesses, as well as a similar situation in Las Vegas, NV.

Mr. Chairman, I am looking forward to hearing from our witnesses this morning. I want to congratulate Dr. Ditzler and Dr. Mayer for the enthusiasm they have shown with respect to sharing, and I want to urge them to continue to explore ways to do even more.

Thank you very much.

Mr. MONTGOMERY. Thank you, Bud Hillis.

Dr. Rowland, do you have any comment?

Dr. ROWLAND. Thank you, Mr. Chairman. I think your opening words place a spotlight on the reason for this hearing. Although it seems to be working very well so far; how can it work better; where are decisions made, at the local, regional or national level, where should sharing take place; and are we really saving money; can we save more money—I think those are the things that we are really here for, and I look forward to the testimony.

Mr. MONTGOMERY. Thank you.

We will have a different order of the witnesses today to allow Dr. Mayer and Dr. Ditzler to hear what the Fleet Reserve Association has to say regarding the change in policy regarding the medical treatment of military retirees. So the Chair would like to call to the witness table Mr. Robert (Bob) Nolan, National Executive Director of the Fleet Reserve Association. Accompanying him will be Mr. Jack Yelverton, the legislative assistant.

Good morning, Bob.

STATEMENT OF ROBERT W. NOLAN, NATIONAL EXECUTIVE SECRETARY, FLEET RESERVE ASSOCIATION

Mr. NOLAN. Good morning, Mr. Chairman. I would ask that you excuse Mr. Yelverton. He had a medical appointment this morning and couldn't be here with us.

My statement is brief.

Mr. MONTGOMERY. Well, we like that.

Mr. NOLAN. But I would like to start with just a little historical fact because oftentimes people hear the thing, "that is what a military man, a military careerist was promised by the recruiter," and I want to lay the groundwork here to show that in the case of medical care for Navy and Marine Corps people there is a little bit more than a recruiter's enlistment or reenlistment promise.

The Fleet Reserve Association is composed of 163,638 members of the organization. They are career enlisted personnel who are serving on active duty or who are retired for reason of length of service or disability. I, myself, am a retired Navy chief petty officer, and I have been privileged to serve my shipmates in my position for 21 years.

Medical care in retirement, military retirement, is second only to military retired pay in the importance of career benefits. To a Navy or Marine Corps retiree, it is perceived and understood as an earned entitlement because from 1798 to 1943 everyone serving on active duty in those two services had 20 cents a month arbitrarily taken from their pay and placed in the old Naval Hospital Fund to provide for their medical care in retirement. It was on that point that the Fleet Reserve Association's legislative program, which we call "Hospital Rights," from 1963 to 1966, was based. FRA's legislative program culminated successfully with the passage of Public Law 89-614 establishing the CHAMPUS program on 1 October 1966. Therefore, it should be evident to one and all why medical care in military retirement is viewed as an earned entitlement by military retirees.

Now, although most military retirees of today are qualified as veterans because of service in two or more wars, care must be taken in discussing their entitlement to receive medical treatment in a VA hospital. This is because the law, of necessity, prescribes certain priorities for the receipt of care in a VA hospital. The treatment of a service-connected disability or illness has priority. Therefore, military retirees who are veterans but who do not have a VA service-connected classification, they may be treated in a VA hospital but they have the lowest priority for receipt of care. And these are the military retirees who seek their medical care in military hospitals.

However, today, the services are curtailing care of military retirees in military facilities, and they are referring these retirees to civilian facilities under CHAMPUS. Under CHAMPUS the retiree must pay a sizable share of the cost. Naturally, military retirees in the vicinity of a VA hospital will seek treatment at the VA hospital at no cost.

The new law, which goes into effect on July 1, 1986, adds a means test to this equation. And given the above conditions, many aged military retirees will certainly qualify for care in VA hospitals and they will seek it in VA hospitals.

In November 1977, the Secretary of Defense commissioned the Defense Resource Management Study. The study was assigned five topics within the broad area of resource management. One of the five topics was the military health care system. Donald B. Rice was the study director, and he issued his final report in February 1979. And that report widely became known as the Rice Study.

On medical care the study concluded "At one time, the military services were generally considered to offer the best medical benefit program in the country. In recent years, however, military personnel, retirees, and dependents appear to be increasingly dissatisfied with it. Unavailability of services, long queues, negative attitude of providers, administrative mix-ups and excessive costs of CHAMPUS, are among the most frequently heard complaints."

Today, 7 years later, in 1986, the situation has not improved one whit; in fact, it has grown worse. The two major reasons we are given for this condition are (1) the shortage of medical professionals, and (2) the rising costs of medical care.

The fact that medical care for retirees is being curtailed at military hospitals is clearly evidenced by the mail we have received in our offices. With your permission, we have some letters we wish to include as part of our testimony. We feel that these letters are truly representative of the problem. The following is a summary of the letters, and I have provided typewritten copies as well as Xerox copies of the original letters.

Mr. MONTGOMERY. Without objection, so ordered.

[See p. 29.]

Mr. NOLAN. We received two letters, from William E. Ridlehoover and William J. Cummings, regarding the availability of care at the Eisenhower Army Hospital medical center at Fort Gordon. A letter from Mrs. Virginia Bento in Oak City, NC, whose husband, 65 years old, has been stricken with Alzheimer's disease for 7½ years. A letter from Howard B. Crusoit of Virginia Beach, VA, regarding the policy of filling prescriptions at a military medical facility. Robert E. Hatcher, Sr. of Ramona, CA, regarding health care at the Naval Hospital in San Diego for his wife, who was a cardiology patient. A letter from Audrey A. Bingham of Fair Oaks, CA, about her father's treatment at Mather Air Force Base. A letter from Columbus Whitehead, Jr. of Uncasville, CT, regarding the medical care situation at the Naval Submarine Base in New London, CT. A letter from T. A. Wright of Half Moon Bay, CA, regarding care in military medical facilities. And another letter from Gerald E. Hinman, BM1, USN (Ret.), of Goose Creek, SC, regarding military health care.

Our receipt of a large volume of such mail prompted us to make inquiries. As previously stated, we were told the shortage of doctors and the rising costs of medical care are at the base of the problem. We suggest to you that you ask the following questions of the Navy. Their answers may prove helpful to you in resolving the problem.

1. What is the percentage or ratio of doctors assigned to active duty care in the Navy in comparison with the other services?
2. What is the ratio of cost per active duty man for all health care in military medical facilities in comparison with the other services?
3. Are the approximate 150,000 shipboard sailors who are provided care by Navy corpsmen entered into the configuration of the overall doctor assignments or overall costs?
4. What is the percentage of use of CHAMPUS by the Navy as compared with the other services?

5. Why is the Navy's CHAMPUS bill so much higher than the other services?

6. What type of care or medical procedures can be attributed to causing the Navy's higher CHAMPUS bills?

7. How does the Navy justify the issuance of a greater number of non-availability statements allowing the people to use CHAMPUS?

8. And what was the Department of Defense physician strength, by year, for the individual services from the abolition of the draft law until 1986?

We believe the answers to these questions will prove to be revealing and informative and will help serve you to reach an effective resolution to the problems you encounter in the sharing of health care resources with the Department of Defense.

Gentlemen, there is a crisis in military health care delivery today. for those who served our Nation in uniform during wartime, be they non-careerists or military careerists, they are fully entitled to receive the medical treatment prescribed under the law. They deserve no less. It would be foolish to see that practice abrogated because two Government agencies responsible for the health care delivery cannot devise a system to effectively share health resources and assure this nation's veterans and military retirees that they will receive the health benefits they are entitled to.

Thank you, Mr. Chairman. The FRA appreciates this opportunity to present its views. And I stand ready to answer your questions to the best of my ability.

Mr. MONTGOMERY. Thank you, Bob.

[The statement of Mr. Nolan appears at p. 25.]

Bud Hillis?

Mr. HILLIS. Thank you, Mr. Chairman.

Mr. Nolan, I want to thank you for a very fine statement. I will certainly carefully keep in mind all the points you have raised here, and particularly those questions. I don't believe I have any further questions to ask at this time.

Mr. MONTGOMERY. Dr. Rowland?

Dr. ROWLAND. Mr. Chairman, I just want to ask one question, if I may, at this point.

Mr. Nolan, thank you very much for your fine testimony. You say the situation with reference to CHAMPUS has not improved one whit. Can you expand on that just a little for me?

Mr. NOLAN. I am speaking in the FRA's view and opinion now, and I personally have been here since the law was enacted. Very frankly, the Department of Defense has never publicized and explained the procedures, and so forth, adequately. In fact, the House Armed Services Committee in 1969 and then again in 1972 held hearings on that very subject. It was left to outside sources to develop. It was so bad that up until a few years ago when military active duty personnel had to start, their dependents had to start using CHAMPUS, the military generally had the feeling they were getting a secondhand benefit or something. They didn't have confidence in the system, just because DOD had never properly publicized it.

They have changed the regulations. They have tried to make emergency decisions, and so forth, things that would seem to be emergency because they would be implemented before the word could be fully put out, and so forth. The rising costs we can agree with because we know what is going on out there. We run the original first supplemental health care military insurance to CHAMPUS.

But CHAMPUS, as I testified in the Senate last month, they have never put the accepted cost containment provisions into the CHAMPUS program that would protect them. They just seem to go from one chaotic move to another. And that is why we have that feeling.

Dr. **Rowland**. Thank you very much, Mr. Nolan.

Mr. Chairman, I believe there are going to be some revisions in the CHAMPUS program that are going to be coming up and I think we will focus on that some in this hearing, also. Thank you.

Mr. **Montgomery**. Thank you. That is an excellent point. Bud and I both serve on the Armed Services Committee, and nobody seems to be totally satisfied with CHAMPUS. It is a real problem.

Mr. Nolan, you have referred in your statement to curtailment of medical care for retirees. Have your members received any kind of official notification, or is this situation an informal change for DOD facilities?

Mr. **Nolan**. I have not been able to see an instruction or a notice put out from a higher source. However, I know from personal experience. I have been going to the doctor myself for hypertension treatments for the past 4 years. Frankly, with the medication I always make good progress, but they check every 6 months, and I have to go out to Bethesda. Within the past 6 months, Bethesda has instituted a new policy. And if you are a retiree or a retiree's dependent, you must call this telephone number to receive an appointment. And if you are an active duty dependent, you would call another number.

Also, it has been reported to me by members in this area that they have been told they can't get certain types of care because of the shortage of and adequate facilities in certain clinics, and so forth. That happened to my wife. My wife was told she could no longer get a certain type of care.

Mr. **Montgomery**. Well, thank you. Thank you very much, Mr. Nolan. Without objections, we will have some other questions maybe for you to answer. We will send them to you so you can submit them for the record. We appreciate you being here and the support that the Fleet Reserve has given us over the years. And thank you for your service.

Mr. **Nolan**. Thank you very much, Mr. Chairman.

[See written committee questions and their response on p. 70.]

Mr. **Montgomery**. I would like to call to the witness stand Dr. William Mayer, Assistant Secretary of Defense for Health Affairs, Department of Defense.

Dr. Mayer broke his foot, and we want to thank him on behalf of the committee for coming in today and being with us. I guess Bud Hillis and I kind of got our hearts broken yesterday, Dr. Mayer, on the amendment to require health care personnel to have to register with the Selective Service System. It was defeated soundly. And as I said earlier, the American Medical Association I thought, in effect, overkilled on this amendment. But that still doesn't get to the problem. And I think I can pledge to you today—and Mr. Hillis is the ranking minority member on the Personnel Subcommittee of the Armed Services Committee—that we are willing to help you any way we can to get your staffing levels up for combat services or medical care for our young personnel if we do have an emergency or have a war.

Some of those figures are frightening. I recall on plastic surgeons you only have 7 percent of what you need, 41 percent of orthopedic surgeons. So what I am saying, if you would make some recommendations to us, my whole point is to help you get the proper and adequate medical care to take care of our people on the battlefield in Europe or the Mideast or wherever. God help us, it will never happen. But we see you need help and we need to do something about it.

Mr. Hillis?

Mr. **Hillis**. Thank you, Mr. Chairman. I just want to second what the chairman is saying, and that I am very happy that we have a chairman of this committee in Mr. Montgomery who will focus attention on this very critical problem. It is one I think generally the public doesn't want to think about because of the horrendousness of it. None of us want to contemplate war, and particularly this part of a war, the casualty aspect of it. I share the chairman's dismay with what happened in the Armed Services Committee yesterday. But perhaps we aren't ready to quite address the problem, and we need some more help from you and your colleagues on filling us in with the information you can give us as to the needs and what you contemplate some of the figures might be and the contingency plans to meet those, and how the VA might fit into those contingency plans through shared arrangements.

The other thing that concerns me, and I hope that you will address, is the VA really equipped to treat young battlefield-type casualties when their physicians have been dealing for years with World War II veterans such as myself and the problems that we have. You know, sugar diabetes and stroke and prostate trouble, and all those kinds of things are a lot different than what happens to you on the battlefield if you are 18 years old and somebody is shooting a gun at you. Are they ready to really practice military medicine, and can joint facilities give some help under those circumstances?

Those are some of the problems I see and I hope you will be able to address.

Mr. **Montgomery**. Dr. Mayer, I should mention Mrs. Holt, a Member of Congress from Maryland, is vefy interested in this situation, too, and she wants to start hearings next week. She opposed my amendment, but she sees the problem, and she wants to get something done. So I would suggest that you also have someone contact her.

Mr. Hillis?

Mr. **Hillis**. One other point. I am considering introducing a bill, Doctor, that would prohibit people over 40 years of age from cleaning swimming pools.

Dr. **Mayer**. I am for that.

[Laughter.]

Mr. **Montgomery**. Dr. Rowland, do you have any comments?

Don Sundquist?

Mr. SUNDQUIST. No comments, Mr. Chairman.

Mr. MONTGOMERY. Dr. Mayer, we are going in session at 11, and we want to be sure and get everybody's testimony. Would you have any objection to us bringing Dr. Ditzler to the witness table.

Dr. Ditzler, I know you brought a team with you, so we will have a panel. We can just cover both subjects, and it might move us along.

STATEMENTS OF WILLIAM MAYER, M.D., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS, DEPARTMENT OF DEFENSE; AND JOHN W. DITZLER, M.D., CHIEF MEDICAL DIRECTOR, VETERANS' ADMINISTRATION; ANDREW MONTANO, DIRECTOR, VA MEDICAL CENTER, ALBUQUERQUE, NM; AND PAUL G. GROGAN, DIRECTOR, VA OUTPATIENT CLINIC, LAS VEGAS, NE

STATEMENT OF WILLIAM MAYER, M.D.

Dr. MAYER. Mr. Chairman, Mr. Hillis, Dr. Rowland, Mr. Sundquist: First, I want to express very sincerely my sense of privilege and honor at the opportunity to talk with this committee because you have been such a firm supporter of military health care and of this remarkably successful partnership that has developed between the Veterans' Administration and the military health services system, which was long overdue, which took a great deal of work to initiate, and which has proven to be one of our most gratifying and successful programs.

I know that you are aware of most of the things that would be in my formal statement and so I will abbreviate it.

Mr. MONTGOMERY. Without objection, your full statement will be put in the record. The same for Dr. Ditzler.

Dr. MAYER. Thank you, sir.

We do have a great need to boast a little about the remarkable progress that has been made under the Veterans' Administration/DOD Sharing Act. You correctly identified the numbers, as well as saying that the numbers don't in and of themselves provide the kind of detail that I am sure the committee wants. And I am prepared to give to you a detailed listing of all the agreements that have been signed and renewed.

Some of the outstanding achievements of this program have occurred with respect to overcoming problems of geographical isolation. For example, in Alaska, where it has been possible to set up a relationship between the Anchorage VA clinic and the Elmendorf Air Force Base in Anchorage and Bassett Army Hospital in Fairbanks.

In parts of the Continental United States we have been able to do some fairly major merging so that we can best utilize the capacity that both of us have. For example, in Memphis, TN, the VA Hospital there is providing over 1,000 inpatient bed days a year to the Navy. Sometimes under this agreement we have arrangements such as the one between VA in Marion and Grissom Air Force Base where they share a board-certified radiologist. Each of them was buying radiological services outside. The chance now together to utilize a single radiologist has saved at least $50,000 a year.

One of the most exciting things is the joint hospital ventures such as the one you mentioned in Albuquerque where Kirtland Air Force Base instead of having to build a whole new hospital can build instead a considerable savings, perhaps $10 million savings, a really comprehensive excellent ambulatory care center and clinic, and use a whole floor of the brand-new state-of-the-art VA hospital that is being built in Albuquerque, which is right next door, to hospitalize patients instead of building a terribly expensive hospital. Those are just a few examples of the kinds of things we are doing.

In addition, Dr. Ditzler and I recently signed a national referral agreement which for the first time regularizes the process of referral, clarifies the reimbursement process because we have a rather complicated reimbursement systems. We are going to extend that relationship by stationing a Veterans' Administration officer at what is called our Armed Services Medical Regulating Office, which is at Scott Air Force Base, and really is the mechanism by which we direct patients from all over the world, as they come back to the States and within the States, to hospitals that are most appropriate for their care.

In addition to setting up the recent referral agreement, we find that our hospitals in both the military departments and the Veterans' Administration have been working on literally a daily basis to promote additional agreements, to ensure compliance with the various laws that govern us and to assess our progress. Quarterly we have a joint services meeting. We publish a newsletter regularly designed to stimulate various hospital leaderships to the multitude of opportunities that exist under this law to share.

As far as the contingency hospitals system goes, as you know we started out with the civilian military contingency hospitals system designed to back-up military beds in case of a war. This has been expanded now to a National Disaster Medical System. Both the VA and all of DOD play a very important part in this. The VA, as you know, is prepared at this point to provide 32,000 beds to support us.

I would be happy to answer further questions, Mr. Hillis, as to my view of the ability of VA hospitals to give the kind of care that we would need for our people. Very briefly, I think that they are abundantly able to do this inasmuch as the initial and critically specialized care of the battlefield is going to occur mostly on and near the battlefield and in the communications zone. From my experience with the VA, my survey of their very, very excellent hospitals, particularly the ones that are associated with medical schools, they are adequately equipped—like Long Beach—to see hundreds and hundreds of patients who need the kind of surgical and medical interventions that our people will need. So I have no anxiety about that at all.

Between the civilian side of the National Disaster Medical System, which has promised us over 72,000 beds, and the 32,000 that the Veterans' Administration can provide, we have today on tap, even allowing for the staffers who might be mobilized, who are in the Reserve and who would have to leave, we still have on tap readily available to us as backup more than 100,000 total beds that can help us very substantially in case of war.

So we fully intend, my esteemed colleague John Ditzler and I and our staffs, to continue what has really been a very positive and innovative relationship that promises to be a great help to us all.

Finally, we are investigating a number of possibilities as our hospitals are aging both in the VA and in the military. Some of our hospitals are really quite old and in need of replacement. So rather than proceed with any such plans independently, we are investigating the possibility in at least 50 different places before either of us as a government agency takes a step toward a major capital investment in plant to consult with the other to make sure that we haven't overlooked some possibility for a joint operation in that respect.

In conclusion, I must say that the Sharing Act which has pulled together the Veterans' Administration and the military departments' medical services has been a landmark piece of legislation. It has started a very sensible, very productive kind of program, and the largest portion of thanks for the initiation of that I realize rests with this subcommittee. So once again I want to thank you for the honor of appearing here and for the opportunity to answer any questions you have.

I am as concerned as Chief Nolan is about the care of retirees and would be very happy to discuss that or any other questions that the subcommittee may have. Thank you very much.

Mr. **Montgomery**. Thank you, Doctor, for that fine testimony.

[The statement of Dr. Mayer appears at p. 47.]

Mr. **Montgomery**. Why don't we have Dr. Ditzler give his testimony, and his full statement will be put in the record. I think that would be good. We can then ask question of both of you and it will help us. We are trying to find out about the sharing agreement, and you two are the keys to it.

So, Dr. Ditzler, you may proceed, sir.

STATEMENT OF JOHN W. DITZLER, M.D.

Dr. **Ditzler**. Thank you, Mr. Chairman, and members of the committee. I have other panel members here to assist in answering any questions you may have on the specifics at Albuquerque, and also Las Vegas. But for the moment let me briefly provide a summary of my written statement.

I am pleased to be here mostly because it shows a sign of cooperation. I really believe that better medical care is being rendered across the board, and I also think we are providing a more cost-effective method of delivery of that care.

To date, 97 medical centers of the VA have negotiated agreements with over 120 of their military counterparts. Since the beginning of this fiscal year alone, 20 VA medical centers have signed agreements with DOD facilities.

Because of the emphasis given to VA/DOD sharing of health resources, every VA medical center within 25 miles of any military medical treatment facility now has at least one resource being shared. And where such facilities are within 50 miles of each other, only six VA medical centers lack sharing agreements. Diagnostic testing is the most frequently shared service. Other agreements cover a broad range of general inpatient and outpatient care services described more clearly in our formal testimony.

I am also pleased to report to you that much progress has been made to prepare for our mission to serve as the principal health care backup to DOD in the event of war or such national emergency. We need to do more.

One hundred and four of our 172 hospitals have been identified as either primary receiving centers or installation support centers in time of crisis. These centers are all located within 50 miles of military installations. The VA medical centers are tasked with providing inpatient and outpatient care to the military personnel assigned to these installations in the event of war or other national emergency. The remaining 68 VA medical centers, called secondary support centers, are prepared to provide backup to the primary receiving centers by accepting transfers of patients or providing health care personnel and other supplies.

Last fall we completed our third system-wide bed availability assessment and that has been reported by Dr. Mayer to you.

In order to accomplish this mission, however, the VA would exercise its authority under Public Law 97-174 to arrange for care for some veteran patients at civilian community hospitals, transfer others to hospitals designated as secondary support centers, and curtail all but emergency admissions at our 71 primary receiving centers in order to give special priority to military personnel who have been wounded and overall support to active duty personnel.

In eight areas of the country, 15 medical centers have a unique role with the VA/DOD contingency planning process. These 15 medical centers were designated as Federal coordinating centers for the Civilian Military Contingency Hospital System and have now fully converted to the National Disaster Medical System—NDMS.

The purpose of the NDMS is to provide a single national medical response which could, first, provide backup medical support to the military medical care system during a national emergency and, second, could supplement state and local medical resources in response to major peacetime disasters.

I thank you, Mr. Chairman, for the opportunity to testify and I am prepared to answer any questions.

[The statement of Dr. Ditzler appears at p. 55.]

Mr. MONTGOMERY. Why don't we have Mr. Montano, who is the Director of the medical center, if he would come forward and briefly tell us how they work out that sharing agreement in Albuquerque?

STATEMENT OF ANDREW MONTANO

Mr. MONTANO. Thank you, Mr. Chairman.

On January 21, 1986, the offices of the Air Force Surgeon General and Veterans' Administration, Department of Medicine and Surgery, signed a memorandum of understanding regarding a pilot project for the sharing of medical resources at the Albuquerque VA medical center. In essence, the agreement provides for the Air Force to lease patient treatment space at our hospital.

In addition, the Air Force will obtain and reimburse our medical center for specialized medical care or ancillary support.

In concert with many organizational elements within the Air Force and Veterans' Administration we are attempting to accomplish the following: Develop a site plan which integrates Air Force structures and optimizes the use of VA medical center land, establish a design and construct subcommittee, establish a telecommunications/ADP subcommittee to initiate coordination of this vital function, and develop a master design and construction schedule

Mr. Chairman, we are mindful that the objectives of this venture are to improve services to our beneficiaries and to reduce overall costs to the Federal Government. I would also add that under no circumstances would eligible veterans be jeopardized as far as care at our medical center.

A great deal of work still lies before us. However, our Air Force and Veterans' Administration staffs are motivated and excited about this prospect and challenge ahead.

Thank you.

Mr. MONTGOMERY. Thank you, sir, for that very fine statement. And I might say that you are a part of history; this is a pioneer venture. And I appreciate you saying that the veterans' health care will not be diminished or slowed down and that we can handle the situation. And of course the same thing applies to the military. We want to continue, on the part of both parties, to get the proper health care.

[The statement of Mr. Montano appears at p. 63.]

Mr. MONTGOMERY. Mr. Grogan, Director, VA Outpatient Clinic. You might update us on the Las Vegas situation.

STATEMENT OF PAUL G. GROGAN

Mr. GROGAN. Thank you, Mr. Chairman, and members of the subcommittee. I have submitted a statement for the record, but I would like to summarize it at this time, if I may.

Mr. MONTGOMERY. Without objection, so ordered.

Mr. GROGAN. In 1972, the VA opened an outpatient clinic in Las Vegas to serve the southern Nevada veteran population. The workload since then has increased from 15,000 to 64,000 visits annually.

At first it was a satellite clinic of the Reno Hospital, but it then became a free-standing clinic, which is part of Medical District 25, embracing southern California and southern Nevada. The closest VA medical center is located 240 miles away at Loma Linda.

In July of 1984, the outpatient clinic at Las Vegas and the U.S. Air Force Nellis Hospital negotiated the first formal sharing agreement. Through this agreement, we would provide pulmonary function testing in exchange for laboratory culture testing from the Air Force. Since that initial agreement, sharing has expanded to include professional, radiological services, lithium level testing, ultrasound examinations and visual field examinations.

The VA is examining the possibility of using a mobile CAT scan which is now available to the Air Force. Studies have been made both by the VA and the Air Force, and also Vector Research Center, about the feasibility for a new Air Force Base hospital. The present one is underutilized because of the age of the facility. The outcome of the Vector research was a recommendation that there be a 135-bed hospital built on the Nellis property with 52 beds available to the VA.

The costs presently for us to send our patients out on contract hospitalization is over $1.5 million a year and the use of CHAMPUS is over $10 million a year. We feel that the costs of constructing this hospital will be much more cost effective.

In addition, the recommendation was that the outpatient clinic in its present location stay as it is for the service of the veterans.

I would like to summarize and give a couple of examples of advantages for both the VA and the Air Force.

It would demonstrate the responsiveness to a multitude of current government and private mandates; that is, the VA/DOD sharing law, OMB/Grace Commission regarding Federal health agency mutual use, the IG and GAO studies regarding expanded agency sharing, and others.

Provides a VA presence without the expense capital and operating fund commitment for a stand-alone medical center.

Essentially satisfies the VA-documented need for a veteran inpatient facility in southern Nevada, one of only two large metropolitan areas in the Continental United States with no VA hospital within either a 4-hour drive or 240 miles.

And extremely cost effective as compared to any alternative or to the present system of using a combination of CHAMPUS or contract hospitalization.

Mr. Chairman, in the year 1990 there will be 100,000 veterans in the Las Vegas catchment area. It is believed that this is an opportunity for the VA and Air Force to be on the cutting edge in governmental health care sharing.

Thank you, Mr. Chairman.

Mr. MONTGOMERY. Thank you very much, Mr. Grogan. About 2 years ago we had hearings in Las Vegas. Were you there then?

Mr. GROGAN. No, sir. I came right afterwards.

Mr. MONTGOMERY. Right after that. Most of the hearings and complaints were about veterans who had to drive 240 miles to southern California for treatment. So it is certainly worth looking into this plan both for Nellis and also for better care for the veteran, and we appreciate you being here today.

[The statement of Mr. Grogan appears at p. 66.]

Mr. MONTGOMERY. Now for questions or comments from the members.

Mr. Hillis?

Mr. HILLIS. Thank you, Mr. Chairman. We have certainly had excellent testimony on all of these points that we have covered. I want to ask about a couple of areas.

First, we were addressing the interplay or intertie in the case of national emergency or war. As I understand it, in the primary centers—and, Dr. Ditzler, you can correct me—many of your VA facilities are built, well, like in my area. We have the Roudebush Hospital in Indianapolis, which is affiliated with Indiana University Medical School. A large portion of the hospital is right on the grounds, on the campus of the medical school.

Would this type of facility be part of the national emergency plan where you could tie into the facilities of the medical schools and major metropolitan areas for health services in the case of a national emergency such as war or some other disaster?

Dr. **Ditzler**. Mr. Hillis, that is exactly correct. I believe the 71 primary centers to which I referred would largely be in the academic affiliation areas where we have essentially all specialties provided. Many of those centers are already providing a complete range of tertiary care. They would certainly be the initial sorting area for those with various battlefield wounds. On the other hand, the wounded service member also must be rehabilitated back to maxinum health status, too. And I believe that although a lot of that is done in tertiary related centers the probability is the veteran would be rehabilitated in those centers that are close to the home of the veteran able to provide the medical services. I think rehabilitation relates also to the wounded soldier being close to his home at the same time.

Mr. **Hillis**. The Veterans' Administration happens to have in certain specialties some of the most advanced programs in the country. I think of Hines Hospital. If there are spinal injuries involved, I am sure that it is——

Dr. **Ditzler**. Well, we have throughout the country approximately 20 facilities with spinal cord injury units, and they can be all over the country if the need arises. This is not to say that other hospitals wouldn't be able to care for a spinal cord injury, but the quality of care I think is highest at the select centers.

Mr. **Hillis**. Also, the VA is very experienced with such injuries as amputations and this sort of thing, which is kind of a specialized area as well.

Dr. **Ditzler**. That is correct. And we now have about 12 specialized prosthetic centers just for amputees where I think the newest techniques have proven to be very beneficial.

Mr. **Hillis**. Mr. Grogan, perhaps this would fall in your area. You see a greater interplay or interchange between this arrangement perhaps like at Nellis and the Las Vegas clinic, sharing of patients. Is the VA, in that situation, going to be able to practice family medicine, to take the family members of active duty, and service the retirees such as you have heard in the testimony of the Fleet Reserve this morning? How do you see that in the future?

Mr. **Grogan**. The concept is that it will be an Air Force hospital for the beneficiaries, also, and for our veteran patients that we now ship to California, Phoenix—wherever the place may be.

Mr. **Hillis**. Is everybody going to come in on the same priority schedule? Is somebody going to be put down at the bottom of the list so that somebody else gets immediate attention?

Mr. **Grogan**. No. We will have 52 beds designated VA beds, but they will be integrated. They will not be put off on the side. There will be no VA versus Air Force beds. They will be integrated, but 52 earmarked.

Mr. **Hillis**. Would you see in the future that if a mother brings in a child that needs a tonsillectomy you would be able to do it there?

Mr. **Grogan**. That would be the Air Force. Yes.

Mr. **Hillis**. That would be the Air Force side?

Mr. **Grogan**. It would be fully staffed by the Air Force for civilian personnel. No VA personnel, except maybe one or two for eligibility, etc.

Mr. **Hillis**. The interplay might be more through the sharing of CAT scan and radiologists, technical people?

Mr. **Grogan**. Yes. Right now, they are using our radiologists when theirs is on vacation. It is on a sharing basis.

Mr. **Hillis**. Thank you.

Mr. **Montgomery**. Thank you very much, Bud.

Dr. Rowland?

Dr. **Rowland**. Thank you very much, Mr. Chairman.

May I say how pleased I am to see Dr. Mayer and Dr. Ditzler sharing the table together so amiably. I hope that is an indication of what we can expect in the future about the sharing of facilities. I welcome all of you here.

As you know, I have been very concerned about this and had contacted your office about getting together to hear what you had to say. Then the chairman scheduled this hearing, so it worked out just right for me.

Mr. Chairman, I have several questions that I would submit for the record, but a couple that I would like to ask now. Dr. Mayer, if I may address you. In Dr. Ditzler's written statement he talked about the agreement with Reese Air Force Base to provide ambulance service for VA patients in Lubbock, TX. And I understand that there are some statutes governing competition between the military and private airlines, so I wonder how this would affect air ambulance services?

And let me go just a little bit further, since you mentioned Alaska and the sharing of facilities up there. What would be the restrictions on transporting nonambulatory VA patients on DOD aeromedical transport aircraft? For example, in Alaska, as much as $500,000 to $1 million might be involved in making transportation part of a VA/DOD sharing agreement. Could you talk with us a little bit about that?

Dr. **Mayer**. Thank you, sir. There is always the question of competition between federally supplied services and those already existing in the community. So far we have not encountered, at least not that I am aware, have encountered any significant resistance from the civil sector in utilizing one another's services, particularly the ambulance services.

It is true that there could be an argument made that if there were a civilian air ambulance available and we used a military plane, the argument I suppose could be made that this was unfair competition.

Dr. **Rowland**. But you haven't had that yet?

Dr. **Mayer**. No, sir, not that I am aware of.

Have you, John?

Dr. **Ditzler**. I understand that we explored it once several years ago and Airlift Command was not very happy about going further because they felt there was a sensitivity here. We have not recently explored it.

Dr. **Mayer**. Certainly in any real emergency there just would be no issue at all.

Dr. **ROWLAND**. Could you address the Alaska situation, transporting personnel there—maybe retirees—to the Continental United States and using DOD aircraft for that?

Dr. **MAYER**. With retirees, sir, there would be no issue at all. We are authorized to move retirees as part of our health system. I think where a veteran was not a retiree there might be some question raised about that.

Dr. **DITZLER**. I think there would be question, although I suspect that legal counsel would say that if we formally signed a sharing agreement specifying that we probably would have been over the hurdle by that time. I know that in Alaska today veterans who have serious heart failure are airlifted to Seattle. And that is rather costly because you have to buy four seats, one for somebody to accompany him and three seats for the stretcher. I know that is very costly.

Dr. **ROWLAND**. Well, that is my point. Under the Sharing Act could you do this for veterans?

Dr. **MAYER**. I see no reason why we couldn't. There may be a legal issue involved that as a nonlawyer I am not aware of. But under a sharing agreement, particularly if the patient's medical condition required as part of his treatment a fairly rapid removal, then as long as there were military aircraft available and the capacity to do it, then I think we would do it.

Dr. **DITZLER**. We haven't really explored that as far as we have need to do, sir.

Dr. **MAYER**. Yes. Thanks for bringing it up. I think we will have to look into that.

Mr. **MONTGOMERY**. Would the gentleman yield?

Dr. **ROWLAND**. Yes, Mr. Chairman.

Mr. **MONTGOMERY**. I know of our bases here in this country, our military bases, I have seen these medical aircraft come in, Dr. Mayer, picking up patients from these smaller bases and taking them to our larger hospitals. Do we have something coming through Alaska that works the Far East, or even I guess could go to Europe by that route, also?

Dr. **MAYER**. We do have regular scheduled medevac coverage in the Pacific, as well as in Europe, and as well as in the Continental United States. Exactly how Alaska fits into that medevac system I can't answer, but I can certainly find out and supply that for you.

Mr. **MONTGOMERY**. Well, if it is coming through there——

Dr. **MAYER**. If it is coming through, there is no issue, as long as there is space.

Dr. **DITZLER**. There is a larger issue, Mr. Chairman. That is, I don't think we have a handle on the care of veterans in Alaska to the degree that I am satisfied with. I think there is a larger issue that doesn't really yet relate to DOD, but shortly I hope to talk with them about.

Mr. **MONTGOMERY**. Thank you.

Don Sundquist of Tennessee?

Mr. **SUNDQUIST**. Thank you, Mr. Chairman.

I appreciate the very expert testimony today and the fact that you are willing to try new things and are working together.

All is not perfect, however. For instance, I would like to follow-up quickly on the transportation aspect of it. It is a minor thing to us, but it is a problem. A son of a 100-percent disabled veteran of Vietnam's, a dependent, was flown to a hospital in Georgia for health care at a military hospital. He died this week. The 100-percent disabled veteran is responsible for paying for the return of that body back to Clarksville, TN. You might say you were doing the family a favor by taking him to a place where there might be better care. But I say, if you take him down there, you have the responsibility for taking him back.

You probably can't give me an answer today. But when we checked into it, the answer was that there is no responsibility when that dependent died for returning the body back to that home. I think that is wrong.

Dr. **Ditzler**. Could you provide me the data about the individual case, and I will promise you a prompt response?

Mr. **Sundquist**. Thank you, Doctor, I will do that.

The other question, one real brief question, and that is, when the physicians from my district were up here, they were talking about the fact that there is a potential for Selective Service registration by physicians. Their suggestion was that they supply, or the AMA supply a list, which is a more up-to-date list by category and everything that you might need. Is that coming up as an issue? Dr. Mayer, or, Mr. Secretary, is that in the plans?

Dr. **Mayer**. That has already been arranged.

Mr. **Sundquist**. So it is going to happen?

Dr. **Mayer**. Yes, sir.

Mr. **Sundquist**. That there will be a Selective Service registration?

Dr. **Mayer**. No, sir. I think, as the chairman said, that was opposed yesterday.

Mr. **Sundquist**. Oh, I apologize for being late. I missed that. Thank you.

Dr. **Mayer**. But we do have a working agreement with the American Medical Association where they will supply us with their entire data base of physicians, even those who don't belong to the American Medical Association. That does not solve the problem of other health professionals and other health providers. While we have started making contact with the American Nurses Association and the various other professional groups, there is no comparable body of data about other health providers.

Mr. **Sundquist**. I apologize for asking a question that has been answered.

Dr. **Mayer**. No, it is a very good question.

Mr. **Montgomery**. I am glad you did. I have got a lot of knots on my head from yesterday, and I would just as soon go into it some more. The gentleman may proceed.

Mr. **Sundquist**. Thank you.

One last question, and that is this. I represent the Tennessee part of Fort Campbell, which is, incidentally, two-thirds in Tennessee and one-third in Kentucky. It always sort of irritates us to have it in Kentucky. But they have a very fine hospital there. An excellent hospital. And the only problem we have with that, as we do with many of our veterans hospitals, is that we can't serve enough people.

I apologize if this question has been asked previously. I go out there periodically and I have a group of veterans that I sit down with as an advisory committee. We go out and meet with the hospital people and we talk about the problems that retirees have had, and they have been very good to work with us. The question, though, that some on the staff have asked, and unofficially, please, is where we pay through CHAMPUS to other hospitals for their health care, isn't it possible that for half or three-fourths of what we would pay for another hospital we could expand that hospital at Fort Campbell. We would have more specialties, serve the people in that area whether they are retirees or active duty personnel more effectively and more efficiently. This would save the Federal Government money because CHAMPUS is all money spent by this Government, and we could spend less money and have better care at that Fort Campbell hospital, and have, in actuality, more people ready for a national emergency? God forbid that we would have to use it.

Dr. MAYER. Your question touches on an issue that is paramount in our concern right now. We had over a year ago for a period of more than 6 months a blue ribbon panel on the sizing of military hospitals, which was required by the Congress. This was a group of distinguished people both from private industry and from academia and from the medical associations and the hospital associations. Their conclusion was that we should size our hospitals with respect first of all to the readiness requirements to take care of wounded soldiers. Secondly, however, we have to take into account the need for training physicians in the specialties needed in medicine and surgery generally as well as in wartime. We needed to take into account the remote locations where there weren't any alternative sources of care. And we had to take into account whether it would be more cost effective, as your constituents propose, to enlarge the military hospital and have it take over more of the dependents and retiree care.

This raises the entire subject of CHAMPUS and the conceptions upon which it is based. Twenty years ago when CHAMPUS was invented it was believed, and I think quite accurately, that the military system could take care of most retirees and dependents who until that time were not under statute entitled to medical care but were provided it very frequently on a space-available basis. When the law made it an absolute entitlement for all retirees, the families of retirees, all families of active duty and survivors of CHAMPUS was a very small sort of safety valve that let us obtain care in the community when we just didn't have a bed or when we didn't have the kind of specialty care needed. CHAMPUS has grown inordinately. It has grown faster in its costs and number of patients than medical care in this country has generally grown, and medical care, of course, has escalated in costs faster than the cost of living, to the point where our $1,350 million CHAMPUS budget this year is probably going to be $400 million or $500 million short, and the reasons are multiple.

But with respect to enlarging the hospital at Fort Campbell, for example, even if this were a higher priority than repairing the hospitals overseas that are the first line of medical defense in the case of war and are today serving nearly one-fourth of the total military population of this country, even if it could be shown that Fort Campbell was a higher priority than that, and if it were expanded—one of the problems that we face is not just funding, but the problem of how many people are authorized to be in the medical services of the armed forces, the ceilings——

Mr. **Sundquist**. Doctor, if I could interject. And I think my time has run out, but my point is essentially this. Sometimes we have a certain amount in this part of the budget, and we have a certain amount of money in that part of the budget. The Grace Commission spoke to this. I don't agree with everything in the Grace Commission, believe me, but I think that somebody has to take a look at this and say, wouldn't it make sense even though it is different budgets. I am not talking about the Fort Campbell expansion at the expense of overseas. I am talking about any hospital of its kind. Wouldn't it make more sense where we are spending *X* dollars per patient on CHAMPUS where we could do it for half the costs in the military hospital, reduce the cost to the Federal Government in its entirety and provide more service and train more people and have more readiness? That is essentially my point, and I don't expect that you can have an answer to that today. I am glad there was a blue ribbon panel that looked at it, but that is the point that I would leave with you and the question that needs to be pondered.

I am sorry I overran my time, and I appreciate your answers.

Mr. **Montgomery**. Thank you. Don, I am not exactly clear on it, but we did make some CHAMPUS changes putting more responsibility on the different Secretaries to see if this could bring about better service and watch the amount of funding that goes in CHAMPUS and try to improve it. We did make some changes in the DOD authorization bill in the Personnel Subcommittee, which I serve on.

I don't want to turn this into talking about registration again, but you brought it up. The problem that we have with the list, Dr. Mayer, like you said, it did not include other groups, and it includes a lot of names that we really didn't need. You know, it was just a list of 500,000 doctors that went to you. And I read the memorandum of agreement, and where the list should be, and I think you would agree with me, it should be over at the Selective Service System. Selective Service System tells us, Don, that they can get the list but they can't move with it until Congress instructs them that they can put this in data processing because it would be violating the Privacy Act by taking this list and having it where they could punch a button and in 12 hours, or 24 hours, they could notify these individuals.

The list sounds pretty good, Dr. Mayer, but I really don't see, other than trying to get some volunteers that you could use it. I don't really see where that list helps you that much.

Dr. **Rowland**. Mr. Chairman, would you yield?

Mr. **Montgomery**. Yes.

Dr. **Rowland**. The question, where I was coming from, is that the physicians, and I understand that there are other groups that aren't that way, I think they would support allowing that information to go on the computers.

Dr. **Mayer**. It is. It is already on computer tapes, and we have direct access to it.

Dr. ROWLAND. I don't think that is a problem, and they would be willing, as I understand in my discussions with them, be willing to update it regularly so that it is this resource. They just didn't feel like they wanted, for whatever reasons, to be signed up for Selective Service.

Mr. MONTGOMERY. Yes; we found that out. You are going to also find out that some of these doctors, and I have talked to some of them, didn't know their names have been sent to Dr. Mayer and that he had their names. They jumped on me, and I said, "Wait a minute. Your name has already gone." They say, "Gone where?" So it is not all over with yet.

Dr. ROWLAND. Mr. Chairman, would you yield?

Mr. MONTGOMERY. Yes.

Dr. ROWLAND. I really don't understand why physicians would be opposed to registering. I think it is an obligation that they have to the country, and I fully support having them register within certain age brackets as to specialty and other information that would be important to the Department of Defense. And I don't support the AMA's position.

Mr. MONTGOMERY. Well, I certainly appreciate that, Dr. Rowland. I still feel if you require 18-year-olds to register, and we need the health care profession in certain areas, we need them. I am very honored you would make that statement. But we are just going to have to take another look at it and see what we need to do.

Let me ask, in your testimony, Dr. Mayer, also I would like to get a little clarification. The testimony of the National Executive Secretary of the Fleet Reserve that we have had this morning regarding the curtailing of medical care for military retirees, what is your near-term plan to help these retirees obtain health care?

Dr. MAYER. First, Mr. Chairman, I must correct Chief Nolan's quite understandable assumption that there has been a policy to exclude retirees from military care in military hospitals. It must be understood that since the very beginning the military hospitals have accepted retirees ever since it was made a requirement in 1966, but with the caveat that they had to have a bed or they had to have the space and the specialists necessary for that patient's needs, so it was on a space-available basis. When what is properly called the Gramm-Rudman-Hollings bill became law, the Deficit Reduction Act, the Deputy Secretary of Defense, William Howard Taft IV, published a memorandum very specifically instructing the Secretaries of the military departments, the Joint Chiefs of Staff, and all of the assorted people beneath them, as follows—this is very important—and I quote:

"Medical care reductions may not be accommodated by transfer of medical workload from military treatment facilities to civilian providers. Such reductions should be achieved by improving productivity, deferring equipment replacement which will not compromise quality of care, eliminating unnecessary travel and taking other management actions that will reduce funding requirements without shifting workload to the civilian sector."

That is the official policy of the Department of Defense. Now I must say that I think the services have, in all good faith, tried to follow that policy insofar as it was possible to do so. There are innumerable instances, however, of hospitals not having sufficient staff and announcing to the people that they serve in a surrounding area—for example, at Bethesda—that they wouldn't give an appointment when the earliest possible date the person could be seen was 2 months down the road.

The Navy also tried to close down some services and reduce the scope of services in several of its smaller hospitals because, for example, in one they needed the surgeon who was there aboard an aircraft carrier, and they couldn't find another place to get the surgical support for the aircraft carrier, so they were going to close down that surgical service that he provided. This was stopped because it was believed by the people in the community that this would be an unjust reduction in service.

So we are faced with a very serious problem not only of accessibility to service, but of the cost to the retiree. We are addressing that in the slightly longer term, as you know, by a proposal that is still in its early stages.

Mr. MONTGOMERY. Have you shut down, in San Diego, the treatment of retirees there in the military hospitals, or are you still seeing military retirees?

Dr. MAYER. I believe that military retirees are still getting care at San Diego, but I would imagine, and this is a statement that has limited accuracy because I don't operate that hospital, and properly the Navy should answer that question, and I will get that question answered for you. But it is my understanding that new patients coming in, particularly those who have certain specialty needs, are being advised to seek care in the community. And these days, at the medical cost levels that prevail in the community, many retirees really can't afford that, so it does present them with a very serious problem. Nonetheless, under the law CHAMPUS is their only alternative, and as you noted earlier, CHAMPUS is a source of great concern, has been for years, and is not getting any better, which is why we want to change it.

Mr. MONTGOMERY. Thank you. My last question. Dr. Ditzler, how do these sharing agreements work? We hope that we will have more sharing agreements, and certainly you have increased by over 200 percent the sharing agreements. Have you worked out a pretty good system between the DOD and the VA? Do all decisions have to come up here to Washington, or how does this work?

Dr. DITZLER. Well, essentially all of the decisions begin in the periphery, in the field area, where the identification of the need is most likely to be observed. They then do go through a process that comes through succeeding official levels, but I don't believe that has ever retarded it. We are still happy to sign up with it wherever we see a cost benefit. So I don't think the coming to Washington with the chain for final approval has hindered the process.

Mr. MONTGOMERY. But they do have to come to Washington for final approval?

Dr. DITZLER. Where we are dealing with substantive things, yes. Otherwise, the regional medical people can do this.

Mr. MONTGOMERY. I was in Orlando, FL, this year talking about sharing agreements in the naval hospital there; you have an outpatient clinic there. I got the impression there were a few problems in trying to work out some sharing agreements, so both parties just slowed down trying to work them out. So that is really where I am coming from on my question.

Dr. DITZLER. I really do not see this as a bureaucratic nightmare. I think it has worked out very well. As an example, Albuquerque, at which millions of dollars would flow in both directions and which involves major policy issues, has been accommodated in the shortest time, probably shorter time than the things we do internally in VA alone.

Mr. MONTGOMERY. Thank you.

Are there any other questions?

Mr. SUNDQUIST. Mr. Chairman, I would ask unanimous consent that we would be able to submit some questions for the record.

Mr. MONTGOMERY. I would also like to submit some questions, and Dr. Rowland or any member of our staff, we ask that you answer these questions.

If there are no further comments, and, Dr. Ditzler, we appreciate the General Counsel and other gentlemen being here this morning. I am sorry we didn't bring them up, but this was very helpful the way we handled this, and I want to thank you gentlemen for giving us this opportunity.

This oversight hearing is now adjourned.

[Whereupon, at 10:55 a.m., the subcommittee was adjourned, to reconvene subject to the call of the Chair.]

APPENDIX

HEALTH CARE FOR MILITARY RETIREES

Before the

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
VETERANS' AFFAIRS COMMITTEE
U. S. HOUSE OF REPRESENTATIVES

Thursday, 26 June 1986

By

ROBERT W. NOLAN, USN (Ret.)
NATIONAL EXECUTIVE SECRETARY
FLEET RESERVE ASSOCIATION

Not for publication until released
by the House Veterans' Affairs Committee

FLEET RESERVE ASSOCIATION
Serving Career Enlisted Personnel of the
U.S. NAVY • U.S. MARINE CORPS • U.S. COAST GUARD
1303 New Hampshire Avenue, N.W., Washington, D.C. 20036
(202) 785-2768

INTRODUCTION:

Mr. Chairman and members of this distinguished Committee, it is my privilege to present to you the views of my 163,638 Shipmates of the Fleet Reserve Association on the subject you are researching today. The Fleet Reserve Association is an organization of career enlisted personnel of the U.S. Navy, Marine Corps and Coast Guard. FRA members may be either serving in active service or retired for length of service or disability. I am a retired Navy Chief Petty Officer. I have served my Shipmates as National Executive Secretary for twenty-one years.

PRESENTATION:

Medical care in military retirement is second only to military retired pay in the importance of career benefits. To a Navy or Marine Corps retiree, it is perceived and understood as an earned entitlement because, from 1798 to 1943 anyone on active duty in those two services had twenty cents a month arbitrarily taken from their pay and placed in the old Naval Hospital Fund to provide for their medical care during their military retirement. It was on that point that the Fleet Reserve Association's legislative program "Hospital Rights" (1963-66) was based. FRA's legislative program culminated successfully with the passage of Public Law 89-614 establishing the CHAMPUS program on 1 October 1966. Therefore, it should be evident to one and all why medical care in military retirement is viewed as an earned entitlement by military retirees.

CARE IN VETERANS ADMINISTRATION HOSPITALS

Although most military retirees of today are qualified as veterans because of service in two or more wars, care must be taken in discussing their entitlement to receive medical treatment in a VA hospital. This is because the law, of necessity, prescribes certain priorities for the receipt of care in a VA hospital. The treatment of a service-connected disability or illness has priority. Therefore, military retirees who are veterans but do not have a VA service-connected classification may be treated in a VA hospital but, they have the lowest priority for receipt of care. These military retirees seek their medical care in military hospitals.

However, today, the services are curtailing care of military retirees in military facilities and referring these retirees to civilian facilities under CHAMPUS. Under CHAMPUS the retiree must pay a sizeable share of the cost. Naturally, military retirees in the vicinity of a VA hospital will seek treatment at no cost there.

The new law, which goes into effect on 1 July 1986, adds a means test to this equation. Given the above conditions many aged military retirees will certainly qualify for care in VA hospitals and they will seek it.

In November 1977, the Secretary of Defense commissioned the Defense Resource Management Study. The study was assigned five topics within the broad area of resource management. One of the five topics was the military health care system. Donald B. Rice was the study director and he issued his final report in February 1979. It became widely known as "The Rice Study". The study concluded,

> "At one time, the military services were generally considered to offer the best medical benefit program in the country. In recent years, however, military personnel, retirees, and dependents appear to be increasingly dissatisfied with it. Unavailability of services, long queues, negative attitude of providers, administrative mix-ups and excessive costs of CHAMPUS, are among the most frequently heard complaints."

Seven years later, in 1986, the situation has not improved one whit, it has grown worse! The two major reasons we are given for this condition are: (1) the shortage of medical professionals, and (2) the rising costs of medical care.

The fact that medical care for retirees is being curtailed at military hospitals is clearly evidenced by the mail we receive in our offices. With your permission we have some letters we wish to include as part of our testimony. We feel that these letters are truly representative of the problem. The following is a summary of the letters and I have provided typewritten copies as well as xerox copies of the original letters.

1. Letters from William E. Ridlehoover of Mc Cormick, SC and William J. Cummings about the availability of medical care at the Eisenhower Army Medical Center at Fort Gordon, GA.
2. Letter from Mrs. Virginia Bento in Oak City, NC whose husband is 65 years and has been stricken with Alzheimers Disease for 7½ years.
3. Letter from Howard B. Crusoit of Virginia Beach, VA regarding the filling of prescriptions policy.
4. Letter from Robert E. Hatcher, Sr., in Ramona, CA re: health care at Naval Hospital in San Diego for his wife who has a cardiology problem.
5. Letter from Audrey A. Bingham of Fair Oaks, CA about her dad's treatment at Mather AFB.
6. Letter from Columbus Whitehead, Jr. of Uncasville, CT re: medical care at the naval submarine base at New London, CT.
7. Letter from T. A. Wright of Half Moon Bay, CA re: care in military medical facilities.
8. Letter from Gerald E. Hinman, BM1, USN (Ret.) of Goose Creek, SC regarding military health care.

Our receipt of a large volume of such mail prompted us to make inquiries.

As previously stated we were told the "shortage of doctors" and "rising costs of medical care" are at the base of the problem. We suggest to you that you ask the following questions of the Navy. Their answers may prove helpful to you in resolving the problem.

1. What is the percentage or ratio of doctors assigned to active duty care in the Navy in comparison with the other Services?
2. What is the ratio of cost per active duty man for all health care in military medical facilities in comparision with the the other Services?
3. Are the approximate 150,000 shipboard sailors who are provided care by Navy Corpsmen entered into the configeration of the overall doctot assignments or overall costs?
4. What is the percentage of use of CHAMPUS by the Navy as compared with the other Services?
5. Why is the Navy's CHAMPUS bill so much higher than the other Services?
6. What type of care or medical procedure can be attributed to causing the Navy's higher CHAMPUS bills?
7. How does the Navy justify the issuance of a greater number of Non-Availability Statements?
8. What was the Department of Defense's physician strength by the year, for the individual services, from the year of the abolition of the draft law until 1986?

We believe the answers to these questions will prove to be revealing and informative and will serve to help you reach an effective resolution to the problems you encounter in the sharing of health care resources with the Department of Defense.

CONCLUSION:

Gentlemen, there is a crisis in military health care delivery today. For those who served our nation in uniform during wartime, be they non-careerists or military careerists, they are fully entitled to receive the medical treatment prescribed under law. They deserve no less. It would be foolish to see that practice aborgated because two government agencies responsible for the health care delivery cannot devise a system to effectively share health resources and assure this nation's veterans and military retirees that they will receive the health benefits they are entitled to.

Thank you, Mr. Chairman. The FRA appreciates this opportunity to present its views. I stand ready to answer questions to the best of my ability.

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P.O. Box 31
McCormick, S.C. 29835

Jan. 14, 1986

Mr. Robert W. Nolan
National Executive Secretary
Fleet Reserve Association
1303 New Hampshire Avenue, N.W.
Washington, D.C. 20036

Dear Shipmate Nolan;

After serving my country in war as well as in peacetime (with very-low pay) from Oct. 1934 untill I retired in Dec. 1964 with 30 full years of continous active service in the regular Navy with most of this time sea duty on board combat ships Cruisers and Destroyers, now at age 72 I am very much upset and disturbed about my Military Health care promised to me which I have worked for and already earned now about to be taken away from me along with certain other military retirees and their family seeking health care at Eisenhower Army medical center Fort Gordon Ga.

On March 1, 1979 I applied for Family Practice at Eisenhower Army Medical Center , and at that time they informed me that it will take about one year for my name to get to the top of the waiting list to be placed in family practice. On Feb. 9, 1983 (4 years later) I received notice from Eisenhower Medical Center notifying me that effective Feb. 8,-1983 the retiree waiting list in family practice was eliminated. I have a strong feeling that a number of names were placed ahead of my name during the four years of waiting, including some that have never served not one day in the military service. Can anyone say that was fair ?

I read with interest the Dec, 6, 1985 article in the Augusta Chronicle newspaper about Eisenhower Army Medical Center charging military retirees for services starting Jan. 1, 1986. Two days later Dec. 8 paper say military retirees enrolled in Eisenhower Army Medical Center's family practice system will not be affected by the center's new plan, requiring other retirees to pay for physicans' fees beginning March 1, 1986. Again I say what is fair about that to require some to pay and others not pay ?? I call it very unfair, unjust, breach of promise and discrimination at its worst. I do not understand how they have the nerve to even consider such unfair and discriminating practice against some military retirees in this great country. If something must and have to be done to cut cost why can't they be fair about it ? I honestly believe that most any lowest rate E-1 Buck Private, or Seaman Recruit with only first day in the service could very easily think of a better and more fair way than what couple high ranking Officer's in charge at Eisenhower Medical Center have so [illegible] and hope to put into effect on March 1, 1986. The newspaper state that Eisenhower is the first of eight Army medical centers in the country to implement this plan Col. Lewis Harden, deputy commander of Clinical services at Eisenhower said. Maybe someone hope for a feather in their hat, or could it be a star they are looking for ? at our expense! It seem their strategy or plan was to get the retirees fighting each other, then divide and conquer.

With the cost of living delayed again at the last minute, Dental care about gone, and now they have plan to start taking our already earned military medical benefits away beginning March 1. What can we military retirees expect next ?? And what can the future military retirees expect and look forward to ??

Mr. Nolan, I consider our already earned and deserved military medical benefits to be very important and anything you can do to prevent this from taken away from us will be greatly appreciated. Do what you can to put a stop to it before it get started at Eisenhower Army medical center on March 1, 1986. If they succeed, it will spread fast.

Sincerely,

William E. Ridlehoover
William E. Ridlehoover
GMGC, U.S. Navy (Retired)

P.S. I have both Medicare and Milicare health insurance for several years but haven't used it yet and do not plan to use it as long as I can continue to get my already earned medical benefits at military Hospital.

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December 31, 1985

William J. Cummins
4612 Durbin Drive
Martinez, GA. 30907

Editor, Naval Affairs;

Have you heard of the latest attack on the benefits of retired service people?

The first paragraph of your "Now Hear This" is just the tip of the iceberg, with more to come, and very soon!!! Do you really believe the funds will be allocated for the 20-bed hospital at the Academy next year?? The closing of all the 50-bed hospitals will just increase the workload at the larger hospitals, which will insure that the new program of medical care (or lack of it)is on its way to promulgation now!!

Do you know that only retirees in the "Family Practice" can now receive medical care without using Champu/Medcare, after March 1, 1986? Is that fair??

From 1936 to 1957 I served my country, its people,Conress, the Senate and the President. I enlisted, and signed a contract of their design (Government), paid the price, as did my wife and children,only to be told that their part of the contract is no longer feasible because they have overspent!!!

My wife, Eileen, had been under treatment at DEAMC for seven years for a hemorragh condition, and on Dec. 3, 1985, after four days of hemorraghing she went to DEAMC for further treatment and was denied treatment because no beds were available. (We were told that this was because of a nurse shortage on two words, and that the nurses there had been pulling 12 hr. shifts for two weeks!!)

Eileen was transported to a private hospital in Augusta for treatment, with the expressed idea that she would be returned to DEAMC in two days to complete the treatment. This did not take place, and Eileen had a partial colectomy on Dec. 11, and was discharged Dec. 18 to home.

Fortunately, we do have Milicare, but without the deductible, so, we will pay $475.00 and possibly some other charges we are not aware of as yet. Several of the Doctors who were involved in the operation have submitted bills to us with requests for immediate payment. (They say they will be glad to help us with the insurance forms.) If we pay these bills now it could mean a large out-of-pocket expenses, plus interest lost at the bank, and re-imbursement sometime later.

We do have the money to do this, but, if another trip to the hospital became necessary for either Eileen or myself in the next few months we could be in a very tight spot.

What will some retirees who do not have 100% supplemental insurance do if they are unexpectedly turned away from a military hospital. Most insurance companies will not cover any illness treated in the last year.

Several hospitals throughout the USA are now starting such programs as the one at DEAMC, and plans are being made to carry this forward until all military hospitals are in the program.

I would appreciate a reply to this letter that could be passed on to other retirees in and around this, the third largest retirement area in the country..

Yours in Loyalty, Protedtion,
and Service.

William J. Cummins

William J. Cummins,0018070
Branch 359

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May 27, 1986

Sirs:

My husband, Joe, retired in 1962 after 20 years in the Navy. He is now 65 years old and has had Alzheimer's disease for 7½ years.

In the last six months I have tried unsuccessfully to get help in caring for him in every way I know. The local Social Services will not respond and the Veterans Administration says there is not any thing they can do because it is not service connected.

Joe receives 10% disability due to the loss of a finger during wartime.

I have Medicare, which can help me if I have to hospitalize him.

I took him to the Veteran's hospital in Durham and they did not even let us see a doctor. He only saw a physician's assistant. I took him for the purpose of helping to stabilize him on his medication.

Could you tell me if I can receive any help now or in the future when he will eventually have to receive specialized nursing care.

Thank you for any info you can supply.

Sincerely
Virginia Bento

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FLEET RESERVE ASSC
WASHINGTON, DC.
20036

DEAR SIR

I SENDING you 20.00 for my member Ship PAY.

NOW I WANT TO ASK YOU SOMETHING AFTER SENDING All THE MAILGRAMS OF THE GRAMM/Rudman/Hollings Bill STill WENT INTO law & NOW AS I READ THE PAPER TODAY THEY ARE going TO STOP giving OUT MEDICINE WITHOUT HAVING A DR'S PRESCRIPTION. THE PHARMACY HERE AT VA BEACH SAID THAT CAUGHT THEM BY SUPRISE THEY DIDN'T KNOW ANYTHING About IT.

WEll IM ON A FIXED INCOME my Wife HASN'T WORKED for 2 YEARS NOW THE MONEY I GET IS A DROP IN THE BUCKET THAT IT TAKES TO GET Along. About THE MEDICINE TAGAMENT OUT SIDE COST $45 for 100 TAbles CODEINE VAlium THE will give ME I GUESS UNLESS THEY CUT THAT OUT before NEXT MONTH I HAVE TO GET SOME THE [illegible] THINK I'll MAKE IT? SINCE I'VE BEEN IN THE Fleet RESERVE I DONT SEE WHERE YOU HAVE DONE SO much AND I'VE TALKED TO OTHER MEMBERS THAT SAID THEY WERE DROPPING OUT, I'M GOING ONE MORE ROUND & SEE WHAT HAPPENS, THEN I'M NOT GOING TO GIVE GOOD MONEY AFTER BAD.

CONGRESS AND All THE REST GOT A RAISE THEY EAT AT THEIR FANCY DISCOUNT DINNING Room. & All OTHER THINGS THEY GET

YOU KNOW IVE NEVER FIGURED IT OUT WHY A MAN WANTS TO SPEND $150,000 $200,000 TO GET IN OFFICE THAT PAYS WHAT $63,000 A YEAR AND MOST OF THEM ARE LAWYERS, OR MILLIONAIRES UNLESS ONE THING - YOU CAN GET THAT ANSWER CAN'T YOU MR NOLAN

WHEN I WAS IN THE NAVY I WAS PROMISED THAT I WOULD BE TAKEN CARE OF & MY FAMILY WELL. YOU CAN'T HARDLY GET GLASSES NO DENTAL WORK IF YOU WANT A HAIR CUT IT MAY TAKE YOU 3-4 HRS IF YOUR DUMB ENOUGH TO WAIT THAT LONG FOR THE ACTIVE DUTY COMES FIRST IN EVERY THING A RETIRED MAN HAS DID HIS WORK 20-24 HOURS A DAY - FOUGHT DURING WWII & KOREAN WAR OH! LETS NOT FORGET THE VET FROM THE LAST MISUNDERSTAND THEY SAY BY NOT GIVING THE RETIRED PEOPLE THE MEDICINE THEY WERE PROMISED THEY CAN ~~got~~ SAVE 1.6 MILLION BY SEPT 30. BUT NOW THEY ARE TALKING ABOUT THE PHILLIPPENES NEED A BILLION DOLLARS THIS ~~both~~ OTHER COUNTRY NEEDS 2 MILLION OR 6 MILLION NOW REAGAN SAYS HE DIDN'T KNOW THERE WAS SO ~~me~~ MANY PEOPLE IN THE US THAT GOES TO BED HUNGARY NO WONDER HE GOT HIS BELLY FULL OF JELLY BEANS I SAW A KID THE OTHER DAY CRYING FOR A PIECE OF CANDY HIS FATHER TOLD HIM HE COULDNT AFFORD IT. I BOUGHT IT FOR HIM I HAD A LITTLE MORE THEN THAT BUT NOT MUCH, SO LETS SEE WHAT YOU GREAT WHITE FATHERS DO ABOUT THIS MEDICAL PROBLEM YOU BE SUPRISED HOW MUCH SOME OR MOST OF THE OVER THE COUNTER DRUGS COST. & PEOPLE LIKE ME THATS am DISABLE HAS TO RAKE & SCRAPE TO GET BY OF COURSE YOU MAKE A GOOD SALARY I KNOW IT WOULDN'T BE AS HARD ON YOU AS IT WOULD ME. LIKE I SAID I'LL GIVE IT ONE ~~last~~ MORE CRACK. I HAVE SEVERAL BUDDIES

& WE ALL JUST DONT SEE THAT YOUR ASSC. IS DOING SO MUCH. THAT INSURANCE. I TALKED TO A INSURANCE MAN AND HE SAID IT WOULD COST A ARM & LEG SO IVE BLOWED OFF MY STEAM NOW. YOU CAN CUSS ME OUT IF YOU FEEL LIKE IT

Youre Truly
C. Howard [illegible]

Mr Melon

Its disgusting when you pick up the paper & see what they are cutting & then turning around and giving it away to other countries that probably wouldn't help us if we needed help. I get so mad to hear all these people they run for office, & when they get in the do what? nothing.

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(202) 785-2768

19470 Laurel Lane
Ramona, CA 92065
June 10, 1986

Fleet Reserve Association
1303 New Hampshire Ave., N.W.
Washington, DC 20036

There seems to be a move afoot at the U.S. Navy Hospital, San Diego, to shunt retiree patients, who are eligible, onto the Medicare system.

On May 27th my wife, who is a cardiology patient, at the Navy Hospital San Diego, was waiting her turn for some laboratory work. An elderly male cardiology patient seated next to her stated that his doctor at the Navy Hospital suggested that he go onto Medicare. As I waited for my wife outside of the laboratory, I chanced to overhear an elderly woman tell a man - ostensibly her husband - that her doctor had said that, "she should go onto Medicare".

My wife has not been scheduled for a recent appointment with her cardiologist and, hence, has not yet received such advice. However, we feel that, because of the above, it may be forthcoming at the time of her next appointment. My wife has an artificial heart valve and an aortic by-pass. The artificial heart valve requires frequent blood tests - every one to three weeks - and daily medication. Appointments with her cardiologist occur at about every fourth month.

Needless to say, if this family is forced to go onto Medicare from the Navy Hospital care, it will hit us in the pocketbook. Since Medicare does not provide full financial coverage, prudence requires that one carry other hospital insurance. Medical monitoring of my wife and concomitant medication must continue without fail for the rest of her life.

Along with a failure to receive our last COLA, the expense of maintaining hospitalization insurance would result in a necessary added expense which translates into a sizeable reduction of disposable retirement income. I was never led to anticipate such a situation when I decided to make the U.S. Navy a career and would consider such a development, should it happen, to be a breach of faith on the part of the United States Government.

Robert E. Hatcher, Sr.
Member No. 0440003

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Audrey A. Bingham
8551 Oak View Lane
Fair Oaks, CA 95628
967-8015 or 366-3779

August 27, 1985

William E. Collins, Colonel,USAF
Commander
Dept. of the Air Force
Headquarters 32D Flying Training Wing (ATC)
Mather Air Force Base CA 95655-5000

Dear Colonel Collins,

Thank you for taking the time to respond to my letter in reference to my father, Ralph A. Mistretta.

Enclosed is a documented history on my father's health and the emergency care he received at Mercy San Juan Hospital following the emergency care he received at Mather Hospital on June 22, 1985.

Discrepancy on the time entering and leaving Mather is a bewilderment to me. My daughter and I entered Mather at approximately 2:30pm and left approximately 8:15pm. The cafeteria times are correct but we were allowed to come in at 5:55pm (my daughter and I) and eat at the table while all the other tables were being cleaned and we never left until 6:30pm.

Col. Williams, I appreciate Ms. Schiedel being available to answer my questions concerning my dad's bills. I may be contacting her at a later time.

My greatest concern now is my father. Just a short time ago he was a spunky senior citizen and now is bed riddened. Could this have been avoided if he had been admitted to Mather Hospital? Some of the things I observed left me very unsure that my dad was getting the correct treatment. Time is of the essence in an emergency situation, and this has been apparent in the case of Ralph A. Mistretta.

What I have written is the truth.

Sincerely,

Audrey A. Bingham
Audrey A. Bingham

FLEET RESERVE ASSOCIATION

Representing All Enlisted Personnel of the
U.S. NAVY ☆ U.S. MARINE CORPS ☆ U.S. COAST GUARD

1303 New Hampshire Avenue, N.W., Washington, D.C. 20036 • (202) 785-2768

September 3, 1985

85 Dydo Drive
Uncasville, CT. 06382

Fleet Reserve Association:

Dear Sir:

I am retired and disabled U.S.N. Veteran. I had been receiving medical attention at the U.S. Submarine Base Hospital, Groton CT. until November 1984. The doctor was transferred with no immediate replacement. I was told to find a civilian doctor and use champus. (I can understand that if you don't have the Dr.'s)

Now after ten months some of the prescriptions written by the outside physican will not be filled by the Hospital Pharmacy. (Even though it's the same medication the hospital physican had prescribed) I am told it's too expensive.

This is a gross erosion of benefits I'm entitled to by virtue of my service and prior promises.

The expense of using champus even with other private insurance is expensive, so because the medication is expensive, (This is the reason the hospital won't fill certain prescriptions), is more reason to receive it from the hospital since they have it available.

I would appreciate any help you can give to restore some of the benefits that are eroded away every few months.

Sincerly Yours
Columbus Whitehead Jr
Columbus Whitehead Jr.
85 Dydo Drive
Uncasville, CT. 06382

Member No. 0112386
Since 07/68

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7/10/85
19 Ocean View Avenue
Half Moon Bay, CA 94019
(415) 726-3754

Fleet Reserve Association
Washington, D.C.

Please don't say "I TOLD YOU SO" or even intimate it, but my dependent son and I have just been told that we would not be seen in the cardiology clinic (@USNH OAKLAND) anymore.

Allegedly, it is due to service staff shortages, but the XO admitted (privately) that it was due to being "under the microscope" with the current hearings on quality of care at military facilities. We receive info thru Naval Affairs, Retired Personnel Newsletter, hospital bulletins, etc., to fully utilize uniformed services medical facilities vs. Medicare and for CHAMPUS; even to the point of requiring the Certificate of Non-availability to utilize civilian medical facilities.

We live within the "sphere of influence," so technically we have to get the "Cert." but that puts us in a "Catch 22" situation. They want us to put pressure on "someone" to re-staff the cardiology division of internal medicine dept. so they can bring their level of care up to what it should be. Who do we contact? We do agree that they need more physicians. We don't agree with the way they are going about it. I have contacted the hospital command in person, as well as sent copies of the notification ltr. (encl.) to my Congressman and Senator.

Do you have a plan? How can I help you, help me?

Rspy. T. A. Wright, USN (Ret.)

I am not covered under your ins. suppl. program, even if I could afford it, so please don't bring that up either. TAW

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7/10/85
19 OCEAN VIEW AVE
HALF MOON BAY,
CA 94019
(415) 726-3754

FLEET RESERVE ASSN
WASH. D.C.

PLEASE don't say "I TOLD YOU SO" or even intimate it, but my dependent son & I have just been told that we would not be seen in the cardiology clinic (@ USNH OAKLAND) anymore.

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Do you have a plan? How can I help you, help me?

Resp'y,
J. A. Wright USN-RET
(over)

I am not coverable under your ins. suppl. program, even if I could afford it, so please don't bring that up either.

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Dear Sir:

I am writing you regarding the article in Dec. issue of Naval Affairs. The enclosed papers will explain to you what is happening to retirees already.

As you know all a politician has to do is make a suggestion to commanders and his will is done.

Not only has Mr. William Mayer, suggested that medical attention for retirees be referred to civilian Drs., but his will is being done.

As you can read yourself my story and the respone I got.

Only after I wrote and sent copies to several Congressmen and Senators did I receive another appointment at the Naval Hospital Charleston, SC and the Dr. I was given the appointment with in October (Dr. Sirna) is giving me the same story that after my next appointment (in mid February 1986) that I have to sign up for Part "B" of Medicare because I cannot be seen anymore.

Dr. Captain Cook as you can read in his reply to Strom Thurmond tried to imply that I was crying wolf and that my perception was all wrong.

I can assure you sir that there is a wolf and retirees are being forced to go on Champus or Medicare, etc. because we are being told that the availability isn't there.

Mr. Nolan they don't keep people in the service with Diabetes and Heart conditions, so how could I be jeopardizing the mission to active duty personnel in that field of medicare.

As it stated in my letter to Mr. Thurman, hospital commanders and Drs. are being told to get rid of retirees and dependents to get them on Champus or Medicare. We are just a burden to them now that were of no use to them anymore.

When a politician speaks, Admirals and Commanders do.

Thank you for taking the time to read all this. I do know that all retirees are in the same boat and there is probably nothing that can be done but I just wanted you to know that what the Asst. Secretary of Defense for Health Affairs has stated in writing has been implemented in the military hospitals without any bills being passed to that affect.

Respectfully, Gerald E. Hinman, BM1 - U.S. Navy Retired

National
Executive Secretary
Robert Nolan
1303 New Hampshire Ave. N.W.
Washington, D.C. 20306

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another appointment at the Naval Hospital Charleston S.C. and the Dr. I was given the appointment with in October (Dr. Sirna) is giving me the same story that after my next appointment (in mid ~~January~~ Feb. 1986) that I have to sign up for Part "B" of medicare because I cannot be seen anymore.

Dr. Captain cook - as you can read in his reply to Strom Thurman tried to imply that I was crying wolf and that my perception was all wrong.

I can assure you Sir that there is a wolf and retirees are being forced to go on Champus or Medicare etc. because we are being told that the availability isnt there.

Mr. Nolan they dont keep people in the Service with Diabetes and Heart Conditions so how could I be jeopardizing the mission to active duty personnel in that field of Medicine.

As I stated in my letter to Mr. Thurman Hospital commanders and Drs. are being told to get rid of retirees and Dependents to get them on Champus or medicare, we are just a burden to them now that were of no use to them anymore.

When a position speaks admirals and Commanders do.

Thanks you for

taking the time to read
all this, I know that
all retirees are in the
same boat and there
is probably nothing that
can be done but I just
wanted you to know that
what the asst Secretary Def.
for Heath affairs has stated
in writing has bean implemented
in the Military Hospitals
without any bills being
passed to that affect.

Respectfully
Gerald C. Hinman BM1
U.S.N. retired.

P.S. please excuse the
poor penmanship and miss
spelled words.

STATEMENT

HONORABLE WILLIAM MAYER, M.D.
ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

before the

Subcommitttee on Oversight and Investigations
Committee on Veterans' Affairs
United States House of Representatives
99th Congress, Second Session

June 26, 1986

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Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
United States House of Representatives

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I appreciate the invitation to appear today to discuss the progress that the Department of Defense and the Veterans Administration have made in efforts to promote the sharing of health resources between the two agencies.

In May of 1982, the President signed Public Law 97-174, the Health Resources Sharing and Emergency Operations Act. In passing this legislation, Congress recognized that during peacetime:

- opportunities exist for sharing of VA and DoD health resources, and,
- sharing arrangements have the potential for benefiting both veterans and members of the armed forces and reducing the cost of medical care to the government.

Further, Congress identified the VA as the primary backup to the military health care system in the event of a war or a national emergency. This has evolved into the VA/DoD Contingency Hospital System.

Progress Made in Implementation

We in the Department of Defense have worked well with our VA counterparts to overcome strong initial resistance and both legal and administrative stumbling blocks to establish a significant number of sharing agreements. Both agencies have adopted a very positive, innovative approach towards implementing the Sharing Act. The commitment to these implementation efforts is evident; the program has grown from 80 agreements signed during fiscal year 1984 to over 200 at the end of 1985. Our most recent assessment indicates that a grand total of 297 VA/DoD sharing agreements have been signed or renewed to-date. These agreements have enabled both DoD and the VA to increase access and utilization for our beneficiaries and to improve utilization of both VA and DoD facilities.

We have been successful in overcoming problems related to geographic isolation. For example, an agreement between the Anchorage, Alaska VA outpatient clinic, the Elmendorf Air Force Base in Anchorage, and the Bassett Army hospital in Fairbanks has ensured that a broad array of inpatient and outpatient services are available to the VA and DoD beneficiaries in this remote region.

We have effected large scale mergers to better utilize existing capacity. The Memphis, Tennessee VA hospital now provides over 1,000 inpatient bed days per year and routine outpatient procedures to the Navy. The Naval hospital, in turn, provides gynecological services and blood to the Memphis VA hospital.

In some instances, we share a single practitioner. In Marion, Indiana, the VA Hospital and Grissom Air Force Base share a board certified radiologist who alternates between the two hospitals. Each hospital saves about $50,000 per year from what they had been paying local consultants for essential radiological services.

Our newest category of sharing agreements has become known as Joint Hospital Ventures. An excellent example of this type of cooperative arrangement between DoD and VA is found in Albuquerque, New Mexico where the Air Force will use a portion of the new VA hospital being constructed adjacent to Kirtland Air Force Base. By using the VA hospital for its inpatient care needs, the Air Force has modified their requirement for a $25.5 million addition/alteration project at the Kirtland Air Force Hospital. Instead, we hope with Congressional support in FY 1987 to construct a clinic adjacent to the VA hospital with a resulting savings of nearly $10 million.

These are but a few examples of the now close to 300 agreements and renewals for the sharing of peacetime medical resources. We are continuing to look for creative ways of sharing resources and of smoothing out the administrative and legal procedures needed to establish these agreements.

One step towards improving the patient referral process was first suggested at the 1983 DoD/VA workshops which implemented the sharing program. It had become apparent that the VA and DoD needed to clarify reimbursement procedures and the referral process for active duty patients. After lengthy negotiations with the Services and the General Counsels of both agencies, Dr. Ditzler and I recently signed a National Referral Agreement that establishes procedures and designates responsibility for each step in the process by which patients are referred and transferred between the health care systems of the two agencies. This same agreement clarifies the reimbursement process to be followed in each of these referrals. The next step in improving the referral and reimbursement process will come with the stationing of a VA officer full time presence at the Armed Services Medical Regulating Office at Scott Air Force Base, Illinois.

Clearly, the success of the VA/DoD Sharing Program is demonstrated in the number and variety of agreements that have been signed. The two agencies are also cooperating well on a daily basis to promote additional agreements, review our compliance with the law, and assess our progress. During the past year, my office initiated quarterly joint-service meetings on the sharing program. With the VA, we publish a quarterly newsletter designed to market the opportunities for additional agreements. This newsletter is sent to each military treatment facility and VA medical center. Dr. Ditzler and I alternately chair the Health Resources Sharing Committee which reviews compliance with the law and implementation of the program, and provides a forum for discussion of future directions.

VA/DoD Contingency Hospital System

Besides providing the legislation required to establish the peacetime sharing program between DoD and VA, the Health Resources Sharing and Emergency Operations Act also gave the VA a critical new medical readiness mission. The VA was directed to serve as the primary backup to the DoD in the event of a war or a national emergency. The two Deparments have made great strides in designing a VA backup system to our contingency system at DoD. Today the system stands ready to provide 32,506 contingency beds for use by DoD in the event of a war or a national crisis.

Future Directions

We believe that we can speak for VA in emphasizing that we intend to continue our positive and innovative approach to full implementation of the Health Resources Sharing Act -- both the peacetime and contingency provisions of this legislation. We have established a functional, coordinated program and are continuing to look to additional opportunities for sharing of resources.

We have plans and discussions underway for the establishment of a mutually supportive framework for health facility planning that will maximize the investment in the two health care systems while ensuring that both the Department of Defense and the Veterans Administration remain capable of meeting their primary missions.

We hope to follow up on the idea of Joint Hospital Ventures such as the arrangement in Albuquerque and another potential for hospital sharing in Las Vegas. We are investigating numerous locations where meaningful sharing of our health care resources can take place. This is particularly true in the Sunbelt where we have growing populations of both DoD and VA beneficiaries.

As medical technological advances result in more sophisticated and usually more expensive equipment, we will be exploring ideas with the VA for joint equipment purchasing and use of items such as MRI's, Lithotriptors, and CAT scanners.

The VA/DoD Contingency Hospital System has come a long way since its initial implementation was begun four years ago. Today it provides a mission essential first line backup system to our own Military Health Services System. We will continue to refine and expand this program to ensure that it will be able to satisfy its mission if required. A joint report on this system will be sent to you, Mr. Chairman, in July. This report will describe the system in detail and will include the bed capacity of the system by medical specialty.

Conclusion

As a result of hard work by the Chairman and members of this Subcommittee, and efforts by dedicated individuals in both DoD and the VA, the Health Resources Sharing and Emergency Operations Program is finding creative solutions to a variety of health care delivery problems at a reduced cost to the federal government during peacetime; it has also been the impetus for establishment of an essential medical capability needed in the event of a national crisis.

STATEMENT OF

JOHN W. DITZLER, M.D.
CHIEF MEDICAL DIRECTOR
DEPARTMENT OF MEDICINE AND SURGERY
VETERANS ADMINISTRATION

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

JUNE 26, 1986

Thank you Mr. Chairman.

I am pleased to appear before the Subcommittee to discuss VA programs and activities under Public Law 97-174 (The Veterans Administration and Department of Defense Health Resource Sharing and Emergency Operations Act).

I would like to begin by bringing you up to date on where we stand with respect to the sharing of health resources with the Department of Defense (DoD). Then, I will conclude with a status report on the progress we have made in getting prepared to serve as the primary backup to the DoD health care system in the event of war or national emergency.

SHARING OF HEALTH RESOURCES

Background

With the passage of Public Law 97-174, the VA and DoD could, for the first time, aggressively seek to develop mutually beneficial sharing agreements covering all hospital services.

In 1983, our Administrator and the Secretary of Defense approved the necessary operating guidelines to implement the new sharing authority. Shortly thereafter, we issued instructional directives to our field facilities.

That same year, VA and DoD conducted a series of 15 workshops in nine cities around the country to inform both VA and DoD personnel of the new sharing opportunities authorized by the law. The principal purpose of these workshops was to bring together VA hospital administrators and physicians with their military counterparts, in many cases for the first time, to "negotiate" mock sharing agreements.

One by-product of the workshops was the development of an interagency sharing newsletter that discusses the various types of agreements negotiated so that innovative ideas can be shared within the VA/DoD systems.

Progress Report

To date, 97 VA Medical Centers (VAMCs) have negotiated agreements with over 120 of their military counterparts. Since the beginning of this fiscal year alone, 20 VAMCs have signed agreements with DoD facilities.

Because of the emphasis given VA/DoD sharing of health resources, every VAMC within 25 miles of any military medical treatment facility now has at least some resources being shared. Where such facilities are within 50-miles of one another, only six VAMCs lack sharing agreements. Diagnostic testing is the most frequently shared service. Other agreements cover a broad range of general inpatient and outpatient care.

For example, agreements have been negotiated in such areas as: purchasing shared use of CT scanners (purchased based on joint agency workloads); leasing of surgical wards; military provision of ambulance services; provision of blood and blood products; VA use of gynecological services at military hospitals; and VA provision of laundry services. Other examples include:

Open Heart Surgery - Cardiologists at the Eisenhower Army Medical Center at Ft. Gordon, Georgia, perform work-ups on DoD patients at their hospital before they are taken to our Medical Center in Augusta for the actual open-heart surgery. This enables the DoD patients to remain near their families and loved ones.

Ambulance Service - The hospital at Reese Air Force Base, Texas provides Ambulance Service for VA patients at our Outpatient Clinic in Lubbock. This sharing of service results in considerable savings for the VA.

Comprehensive Services - In Memphis, Tennessee, our medical center provides a broad array of both inpatient and outpatient services to personnel being cared for at the nearby U.S. Navy hospital at Millington.

Physician Services - The U.S. Air Force (USAF) at Grissom, Indiana and the VAMC in Marion routinely share the services of a DoD board-certified radiologist. This results in savings of about $50,000 per year when compared to what the government had been spending for local consultants.

Primary Services - Our Medical Center in Portland, Oregon has an agreement with the U.S. Navy to treat personnel attached to ships in drydock in that city. We also have a separate agreement with the U.S. Navy covering shore personnel stationed in the area.

Specialized Services - VA patients in Dayton, Ohio now receive hyperbaric oxygen treatment from the USAF Hospital at Wright-Patterson at a cost of only $13.00 per treatment. Once we determine the utilization pattern, we plan to make our Dayton Medical Center a referral center for other VAMCs for this low-cost treatment.

Education and Training - A number of our VAMCs have negotiated education and training agreements with DoD medical corps reserve units under which they provide on-site training. Our VAMCs often utilize the additional DoD manpower on weekends. Public Law 97-174 makes it possible to integrate training and education into larger agreements with the military.

After two and one-half years of sharing health resources with DoD, we estimate the dollar volume for this exchange of services to be in the $25 million range. Because our health care system is much larger than that of DoD, we provide more services to DoD then they do to the VA (the ratio is about 65% to 35%).

VA/DoD sharing agreements have also been negotiated at the national level. Earlier this month, for example, Dr. Mayer and I signed an agreement that for the first time establishes a referral process for active-duty patients to VAMCs from military or civilian hospitals. Since reimbursement to the VA hospitals is based on the sharing law, our hospitals will retain reimbursement for services provided, thus providing an incentive to accept these patients. Previously, the funds (about $18 million per year) went to the Federal Treasury. In addition, the VA and DoD have taken the following initiatives.

Both the Veterans Administration and the Department of Defense are aggresively addressing potential joint hospital ventures and exploring the possibility of joint equipment acquisitions.

Significant numbers of VA and DoD beneficiaries have already reaped the benefits of expanded services at lower costs. These benefits will continue to expand in the future as more administrators and physicians become more familiar with the inherent opportunities of Public Law 97-174.

HEALTH CARE BACKUP TO DOD

I am quite pleased to report to you that a great deal of progress has been made in carrying-out our mission to serve as the principal health care backup to DoD in the event of war or national emergency. Plans have been jointly developed by VA and DoD to implement Public Law 97-174 by establishing a VA/DoD Contingency Hospital System.

One hundred and four of our 172 VAMCs have been identified as either Primary Receiving Centers or Installation Support Centers. These centers are all located within 50 miles of military installations. The VAMCs are tasked with providing inpatient and outpatient care to military personnel assigned to these installations in the event of war or national emergency. The remaining 68 VAMCs, called Secondary Support Centers, are prepared to provide backup to the Primary Receiving Centers by accepting transfers of patients or providing health care personnel and/or supplies.

Last Fall, we completed our third system-wide bed availability assessment. The VA is now in a position to provide DoD 20,332 staffed operating beds within 72 hours and a total of 32,506 beds during the first 30 days. Assessments were made in 11 specific bed categories required by DoD. Based on several planning criteria, the assessments take into account several important variables. One such factor is the impact on local operations of VA employees subject to mobilization. The VA was requested and has sought to achieve an objective of providing DoD with 25% of our operating bed availability within 72 hours of system activation.

In order to accomplish this mission, the VA would exercise its authority in the event of war or national emergency under PL 97-174 to arrange for care of some veteran patients at civilian community hospitals, transfer others to hospitals designated as secondary support centers, and curtail all but emergency admissions at our 71 primary receiving centers, in order to give priority to active-duty military personnel over all but service-connected beneficiaries.

Detailed information about bed availability by DoD evacuation category at each VA Medical Center have been provided to DoD planners (e.g., OSD/HA, JCS, Surgeon Generals Army, Navy, Air Force, and ASMRO).

Each VAMC involved in this program has appointed a liaison person to work with the military planners. All have appropriate security clearances.

We have established contingency planning work groups in all 27 VA Medical Districts. These groups include local military planners as ex-officio members. Through our Medical District Initiated Program Planning (MEDIPP) process, our managers develop detailed contingency plans which are updated annually.

All of our Primary Receiving Centers and many of our Secondary Support and Installation Support Centers have participated in local, area or regional joint exercises with DoD.

A VA Control Center for Medical Facilities Disasters has been established and is operational.

A VA/DoD Contingency Planning Task Force, which is composed of representatives of my staff, Dr. Mayer's staff, and the staffs of the Surgeons General of the Armed Forces meet monthly to discuss issues of mutual concern.

In eight areas of the country, 15 VAMCs have a unique role in the VA/DoD contingency planning process. These 15 medical centers were designated as Federal Coordinating Centers for the Civilian Military Contingency Hospital System (CMCHS) and have now fully converted to the National Disaster Medical System (NDMS). An additional 21 VAMCs have appointed interim liaisons to assist DoD in expansion of NDMS and to assure operational responsibility upon receipt of dedicated resources. NDMS is designed to backup the VA/DoD Contingency Hospital System in time of war or national emergency.

CMCHS was established by DoD directive in 1980. It was a system designed to sign up civilian hospitals in 48 metropolitan areas to commit beds to care for combat casualties returning from an overseas conventional war. CMCHS formed the base for the expanded (71 areas) National Disaster Medical System.

The purpose of the NDMS is to provide a single national medical response which could: (1) supplement state and local medical resources in response to major peacetime disasters and (2) provide backup medical support to the military medical care system during a national security emergency.

To date more than 900 non-Federal civilian hospitals have committed over 70,000 beds to the system. The coordinators in the VA managed areas have solicited memorandums of understanding which account for 22% of the hospitals and beds in NDMS.

Although we are confident that our planners working with their DoD counterparts are coming up with realistic plans, we realize that all of the problems in this area have not yet been resolved. However, we will continue to strive to perfect the system and will keep you informed of our progress.

That concludes my formal statement to the Subcommittee. I will be pleased to try to answer any questions that you may have.

STATEMENT
BY
ANDREW MONTANO
DIRECTOR, VETERANS ADMINISTRATION MEDICAL CENTER, ALBUQUERQUE, NEW MEXICO
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
HOUSE VETERANS' AFFAIRS COMMITTEE
HOUSE OF REPRESENTATIVES
ON
JUNE 26, 1986

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

I APPRECIATE THE OPPORTUNITY TO APPEAR BEFORE THIS COMMITTEE TO TESTIFY ON VA/AIR FORCE SHARING.

ON JANUARY 21, 1986, THE OFFICES OF THE AF SURGEON GENERAL AND VETERANS ADMINISTRATION DEPARTMENT OF MEDICINE AND SURGERY SIGNED A MEMORANDUM OF UNDERSTANDING REGARDING A PILOT PROJECT FOR THE SHARING OF MEDICAL RESOURCES AT THE ALBUQUERQUE VA MEDICAL CENTER. THIS AGREEMENT APPROVED THE EXPANSION OF THE SCOPE OF LOCAL SHARING ARRANGEMENTS THAT WERE ALREADY UNDERWAY AND EXTENDS OUR IMPLEMENTATION OF PUBLIC LAW 97-174. THE ALBUQUERQUE VA MEDICAL CENTER IS PRIVILEGED TO BE IN THE FOREFRONT OF THIS PRECEDENT SETTING ACTIVITY. IN ESSENCE, THE AGREEMENT PROVIDES FOR THE AIR FORCE TO LEASE PATIENT TREATMENT SPACE AT THE ALBUQUERQUE VAMC.

IN ADDITION, THE AIR FORCE WILL OBTAIN AND REIMBURSE THE VA FOR SPECIALIZED MEDICAL CARE AND/OR ANCILLARY SUPPORT. SPECIFIC DETAILS ARE BEING WORKED OUT BY LOCAL PERSONNEL IN COORDINATION WITH APPROPRIATE VA/AF HEADQUARTERS.

COL. FRED BROWN, M.D., KIRTLAND AFB HOSPITAL COMMANDER, AND I ARE PLEASED TO REPORT WE HAVE MADE SIGNIFICANT PROGRESS SINCE JANUARY. IN CONCERT WITH MANY ORGANIZATIONAL ELEMENTS WITHIN THE AIR FORCE AND VETERANS ADMINISTRATION WE HAVE:

- DEVELOPED A SITE PLAN WHICH INTEGRATES AIR FORCE STRUCTURES AND OPTIMIZES USE OF THE VA MEDICAL CENTER LAND. IT SHOULD BE NOTED THIS JOINT DEMONSTRATION PROJECT ENVISIONS CLOSING THE KIRTLAND HOSPITAL AND MOVING ALL AIR FORCE ACTIVITY TO THE VA CAMPUS. NEW AIR FORCE OUTPATIENT AND DENTAL CLINICS WOULD BE BUILT ON THE VA CAMPUS IMMEDIATELY ADJACENT TO THE VA'S NEARLY COMPLETED 500,000 GSF MAIN HOSPITAL BUILDING — 380 BED CLINICAL SERVICES ADDITION (CSA). THE VA PLANS TO ADD A NEW 30 BED SPINAL CORD INJURY BUILDING ADJACENT TO THE CSA. PARENTHETICALLY, I SHOULD ADD THAT AIR FORCE CONSTRUCTION IS FINANCED THROUGH THE MILITARY CONSTRUCTION PROGRAM. THE AIR FORCE EXPECTS TO SAVE APPROXIMATELY 10 MILLION DOLLARS IN BUILDING COSTS SINCE THEIR REQUIREMENT FOR REPLACEMENT OF A HOSPITAL WILL BE MET THROUGH A LEASING ARRANGEMENT WITH THE VA. WITH THREE NEW STRUCTURES ABOUT TO BE DESIGNED, IT WAS IMPORTANT TO HAVE A WELL CONSIDERED SITE SCHEME FROM THE OUTSET, ESTABLISH CLEAR CONSTRUCTION BOUNDARIES, AND INSURE THE RESULTING "WHOLE" WOULD SATISFY EVERYONE'S PARKING, TRAFFIC FLOW, UTILITY AND RELATED NEEDS.
- ESTABLISHED A DESIGN/CONSTRUCT SUBCOMMITTEE. THIS BODY PULLS TOGETHER ASSOCIATED GOVERNMENT AND CONTRACT ARCHITECTS AND PROJECT MANAGERS, GIVING ALL A METHODOLOGY TO HIGHLIGHT AND RESOLVE THE MYRIAD OF MUTUAL CONCERNS THROUGHOUT THE DESIGN/BUILD EFFORT.
- ESTABLISHED A TELECOMMUNICATIONS/ADP SUBCOMMITTEE TO INITIATE COORDINATION OF THIS VITAL FUNCTION. WE ARE AWARE OF VARIOUS AIR FORCE/VA COLLABORATIVE EFFORTS BETWEEN MARCH AFB AND ADJACENT VA MEDICAL CENTERS TO JOINTLY EXPLORE ADP APPLICATION. WE WILL RESEARCH THIS EFFORT AND CONSIDER HOW BEST TO MEET OUR UNIQUE NEEDS, WITH COMMON HARDWARE/SOFTWARE, IF POSSIBLE.
- DEVELOPED A MASTER DESIGN/CONSTRUCTION SCHEDULE. THIS HAS SHOWN US THE CRITICAL PATH AND YIELDED MAJOR MILESTONE DATES. FOR EXAMPLE, WE FORECAST:
  - — OCCUPYING THE CSA ABOUT JANUARY 1987.
  - — MOVING AIR FORCE INPATIENTS TO THE CSA ABOUT THREE MONTHS LATER.
  - — COMPLETING ALL NEW CONSTRUCTION (SCI, AF OUTPATIENT AND DENTAL CLINICS) AND MOVE THE REMAINING AIR FORCE ACTIVITY TO THE VA CAMPUS IN LATE 1989.

THE ABILITY TO MEET THIS SCHEDULE AND MILESTONES IS CONTINGENT UPON CONGRESSIONAL APPROPRIATION OF FUNDS IN FY 1987 FOR THE AIR FORCE CLINIC.

AT THIS POINT, I WISH TO HIGHLIGHT THAT CONSTRUCTION TIMELINES ESTABLISH HOW LONG IT WILL TAKE TO COLOCATE ALL AIR FORCE AND VA MEDICAL ACTIVITY. HENCE, WE MUST CONCENTRATE ON THESE MATTERS DURING THE EARLY MONTHS OF JOINT PLANNING GROUP ACTIVITY.

COL. BROWN AND I HAVE BEGUN EXPLORATORY DISCUSSIONS ABOUT A HOST OF NON-CONSTRUCTION, OPERATIONS MATTERS. AIR FORCE INPATIENT CARE WILL BE CONDUCTED ON THE 6TH FLOOR OF THE CSA AND IN VARIOUS SPECIALIZED AREAS OF THE CSA. WE HAVE DISCUSSED USE OF SPACE AND ANCILLARY SERVICE RESPONSIBILITIES. DURING THE NEXT FEW MONTHS WE WILL CONTINUE OUR DIALOGUE UNTIL A DETAILED CONCEPT OF OPERATIONS EMERGES. THIS STARTING POINT WILL CONTINUE TO BE REFINED AS WE JOINTLY GAIN EXPERIENCE.

MR. CHAIRMAN, WE ARE MINDFUL THAT THE OBJECTIVES OF THIS VENTURE ARE TO IMPROVE SERVICES TO OUR BENEFICIARIES AND TO REDUCE OVERALL COSTS TO THE FEDERAL GOVERNMENT. IN REGARD TO SERVICES, WE BELIEVE THE ENTIRE BENEFICIARY COMMUNITY (AF AND VA) WILL BENEFIT SINCE HEALTH CARE WILL BE DELIVERED IN NEW FACILITIES, CONTAINING THE LATEST STATE-OF-THE-ART TECHNOLOGY, BY STAFF OFFERING A FULL RANGE OF PRIMARY, SECONDARY AND SPECIALIZED CARE. VA MEDICAL CENTER STAFF HAVE BEEN AUGMENTED TO INSURE THE NEW CLINICAL SERVICES ADDITION CAN BE FULLY UTILIZED. HENCE, OUR VETERAN BENEFICIARIES WILL BE PROVIDED CARE WITHOUT ANY INTERFERENCE DUE TO THE AIR FORCE PRESENCE. CONVERSELY, ADDITION OF THE AIR FORCE PATIENT LOAD WILL PRODUCE HIGH OCCUPANCY RATES IN THE CSA AND ASSOCIATED EFFICIENCIES. COST, UTILIZATION RATES, AND OTHER QUALITATIVE/ QUANTITATIVE MEASURES WILL BE COLLECTED AND ANALYZED BEFORE AND DURING THE COLOCATION PROCESS. THIS WILL GIVE US "HARD" DATA TO DEMONSTRATE THE COST EFFECTIVENESS OF SUCH ARRANGEMENTS.

IN SUMMARY, OUR DIRECTION IS CHARTED, WE HAVE A SENSE OF HOW LONG IT SHOULD TAKE TO GET THERE. WE HAVE THE ORGANIZATIONAL MEANS IN PLACE TO MANAGE PROJECT ACTIVITY AND KEEP IT ON TRACK. WE HAVE TASKED OURSELVES TO CAPTURE LESSONS LEARNED FOR LATER VA/DOD APPLICATION. A GREAT DEAL OF WORK STILL LIES BEFORE US. HOWEVER, OUR AF AND VA STAFFS ARE MOTIVATED AND EXCITED ABOUT THE PROSPECTS AND CHALLENGE AHEAD.

STATEMENT
BY
PAUL G. GROGAN
DIRECTOR, VETERANS ADMINISTRATION OUTPATIENT CLINIC, LAS VEGAS, NEVADA
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
HOUSE VETERANS' AFFAIRS COMMITTEE
HOUSE OF REPRESENTATIVES
ON
JUNE 26, 1986

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

IN 1972, THE VA OPENED AN OUTPATIENT CLINIC IN LAS VEGAS TO SERVE A BURGEONING VA POPULATION. WORKLOAD HAS INCREASED TREMENDOUSLY THROUGH THE YEARS AND THE CLINIC CURRENTLY PROVIDES FOR OVER 64,000 VISITS ANNUALLY.

INITIALLY A SATELLITE CLINIC TO THE RENO HOSPITAL, THE OUTPATIENT CLINIC IS NOW A FREE-STANDING FACILITY WHICH IS PART OF MEDICAL DISTRICT 25, ENCOMPASSING SOUTHERN CALIFORNIA AND SOUTHERN NEVADA. VA MEDICAL CENTER, LOMA LINDA, IS THE CLOSEST VETERANS HOSPITAL LOCATED 240 MILES FROM LAS VEGAS. THE ONLY OTHER GOVERNMENT OWNED HEALTH CARE FACILITY IN THE VICINITY IS THE USAF NELLIS HOSPITAL, A SMALL BUT ACTIVE 55-BED FACILITY LOCATED 8 MILES NORTH OF THE CITY OF LAS VEGAS.

IN JULY 1984, THE VA OUTPATIENT CLINIC, LAS VEGAS, AND THE USAF NELLIS HOSPITAL NEGOTIATED THEIR FIRST FORMAL SHARING AGREEMENT. THROUGH THIS AGREEMENT, THE VA WOULD PROVIDE PULMONARY FUNCTION TESTING IN EXCHANGE FOR LABORATORY CULTURE TESTING FROM THE AIR FORCE. SINCE THE INITIAL AGREEMENT, SHARING HAS EXPANDED TO INCLUDE PROFESSIONAL, RADIOLOGICAL SERVICES, LITHIUM LEVEL TESTING, ULTRASOUND EXAMINATIONS AND VISUAL FIELD EXAMINATIONS. VARIOUS MANAGEMENT AND PROFESSIONAL TRAINING OPPORTUNITIES ARE ALSO MADE AVAILABLE BY EACH AGENCY ON A SPACE AVAILABLE BASIS.

PREVIOUSLY, MANAGEMENT PERSONNEL FROM THE VA CLINIC AND THE NELLIS HOSPITAL HAD MET ON AN AD HOC BASIS; THIS HAS SINCE BEEN FORMALIZED AND QUARTERLY MEETINGS ARE NOW HELD. AT THE LAST MEETING ON JUNE 2 OF THIS YEAR, ADDITIONAL OPPORTUNITIES FOR SHARING WERE EXPLORED. THE VA IS EXAMINING THE POSSIBILITY OF UTILIZING A MOBILE CAT SCAN UNIT AVAILABLE AT THE AIR FORCE FACILITY; MAMMOGRAM TESTING CAN ALSO BE DONE FOR VA REFERRALS. ADDITIONALLY, AIR FORCE AND VA PERSONNEL ARE EXPLORING THE POSSIBILITY OF A CONTRACT FOR PSYCHIATRIC FACILITIES IN THE COMMUNITY. IT IS ANTICIPATED THAT THE COMBINED PATIENT VOLUME COULD BE USED TO NEGOTIATE A FAVORABLE PRICE AND REDUCE THE INPATIENT PSYCHIATRIC EXPENDITURES OF THE TWO FACILITIES.

PERHAPS OF MORE INTEREST TO THE AIR FORCE AND VA IS THE DEVELOPMENT OF A CONCEPT TO JOINTLY CONSTRUCT AND OPERATE UNDER AF COMMAND A HOSPITAL IN LAS VEGAS.

IN FY 1983, THE VA'S WESTERN REGION, MEDICAL DISTRICT 25, AND THE INSPECTOR GENERAL CONCURRENTLY REALIZED THE POTENTIAL FOR MAJOR SERVICES AND COST EFFECTIVENESS IMPROVEMENTS WHICH COULD RESULT FROM ALIGNING THE LAS VEGAS OPC WITH A THEN-DEVELOPING AIR FORCE PLAN TO EXPAND AND/OR UPGRADE THE SMALL 55-BED NELLIS AFB HOSPITAL. AFTER SEVERAL MONTHS OF INTERNAL AND EXTERNAL DISCUSSIONS AND EVALUATIONS, THE FORMAL CAPABILITY FOR A RESOURCE SHARING AGREEMENT WAS IDENTIFIED IN TWO SPEARATE STUDIES, A VA (MEDIPP) FEASIBILITY STUDY AND AN AIR FORCE ECONOMIC ANALYSIS STUDY OF THE NELLIS AFB HOSPITAL NEEDS. THESE TWO STUDIES SERVED AS THE IMPETUS FOR A JOINT VA/AF FUNDED RESEARCH PROJECT (PERFORMED BY VECTOR RESEARCH, INC., OF ANN ARBOR, MI) TO FURTHER INVESTIGATE THE POTENTIAL, VIABILITY AND LIKELY OUTCOME OF SUCH A "JOINT VENTURE" INPATIENT AGREEMENT.

BOTH EARLY REPORTS REVEALED THE SERIOUS RESTRICTIONS, DEFICIENCIES AND DISADVANTAGES OF THE CURRENT SITUATION. FIRST, RELYING ON THE COMMUNITY FOR HEALTH CARE NEEDS IS NOT A COST EFFECTIVE METHOD OF HEALTH CARE DELIVERY. IN 1985, THE VA CLINIC EXPENDED 1.5 MILLION DOLLARS FOR FEE BASIS HOSPITALIZATION AND EXPENDITURES BY THE AIR FORCE THROUGH CHAMPUS EXCEEDED 10 MILLION DOLLARS. HEALTH CARE COSTS IN LAS VEGAS ARE AMONG THE HIGHEST IN THE NATION.

SECOND, THE PRACTICE OF SENDING PATIENTS TO SOUTHERN CALIFORNIA VA MEDICAL CENTERS IS, AT THE VERY LEAST, AN INCONVENIENCE TO PATIENTS. DIFFICULTIES ASSOCIATED WITH THIS PRACTICE INCLUDE: DELAYS IN ADMISSION UNTIL BEDS BECOME AVAILABLE IN CALIFORNIA; UNCOMFORTABLE AND POORLY SCHEDULED TRANSPORTATION OPTIONS; A LACK OF FAMILY SUPPORT FOR PATIENTS SINCE RELATIVES ARE NOT TRANSPORTED WITH THE PATIENT; AND THE INABILITY OF THE VA TO IMPLEMENT SERVICES IN LAS VEGAS, SUCH AS A HOME CARE PROGRAM WHICH REQUIRES READY ACCESS TO AN INPATIENT FACILITY.

BECAUSE OF THESE FACTORS, THE VA MEDICAL DISTRICT 25 AND THE AIR FORCE BOTH RECOMMENDED THAT INCORPORATING A LARGE NUMBER OF VETERAN BEDS INTO THE PLANNED NELLIS FACILITY WOULD BETTER AND MORE COST EFFECTIVELY SERVE THE SEVERAL DISTINCT FEDERAL CONSTITUENCIES WHICH EACH AGENCY SERVES.

AFTER SEVERAL INTER-AGENCY MEETINGS AND REVIEWS OF THE VECTOR JOINT VENTURE STUDY, THE VA AND AIR FORCE HAVE NOW RECEIVED AND ANALYZED VECTOR'S FINAL REPORT. IT RECOMMENDS A NEW 135-BED AIR FORCE OPERATED HOSPITAL WHICH WOULD PROVIDE ACUTE MEDICAL AND SURGICAL CARE FOR UNIFORMED SERVICES' BENEFICIARIES AND VETERANS. OF THE 135 BEDS, THE DEMOGRAPHIC STUDY REVEALED A NEED FOR 83 BEDS FOR THE AIR FORCE AND 52 BEDS FOR THE VA.

THE AIR FORCE AND VA INPATIENT FACILITIES WOULD BE INTEGRATED SO THAT HEALTH CARE IS JOINTLY PROVIDED TO UNIFORMED SERVICE BENEFICIARIES AND VETERANS. THE USAF HOSPITAL, NELLIS, WOULD INCLUDE CLINIC FACILITIES FOR PROVIDING OUTPATIENT CARE TO UNIFORMED BENEFICIARIES. IT IS RECOMMENDED, HOWEVER, THAT THE MAJORITY OF VETERAN OUTPATIENT CARE CONTINUE TO BE PROVIDED AT THE CURRENT VA OUTPATIENT CLINIC, WHICH IS A MODERN FACILITY WITH A RANGE OF SERVICES THAT ARE TAILORED TO THE NEEDS OF VETERANS.

THE AIR FORCE WOULD BUILD, OPERATE AND STAFF THE NEW HOSPITAL WITH THE VA REIMBURSING THE AIR FORCE UNDER A NEGOTIATED SHARING AGREEMENT. THE COST OF THE NEW FACILITY IS $69.6 MILLION (1991 DOLLARS); THIS REPRESENTS AN INCREASE OF $10.9 MILLION OVER THE $58.7 MILLION FOR AN AIR FORCE FACILITY WITHOUT VA PARTICIPATION.

ADVANTAGES OF THE JOINT VENTURE INCLUDE THE FOLLOWING:

- CAPITALIZES ON THE "FORTE" OF MEDIUM-SIZED AIR FORCE HOSPITALS (INEXPENSIVE, QUALITY ACUTE CARE).
- DEMONSTRATES RESPONSIVENESS TO A MULTITUDE OF CURRENT GOVERNMENT/PRIVATE MANDATES -- VA/DOD SHARING LAW, OMB/GRACE COMMISSION RE FEDERAL HEALTH AGENCY MUTUAL USE, IG/GAO STUDIES RE EXPANDED AGENCY SHARING, ETC.
- DISPLAYS AIR FORCE AND VA INNOVATION SINCE THE PROPOSED SOLUTION IS A "PROTOTYPE INTEGRATED" AF/VA INPATIENT FACILITY.
- PROVIDES A VA PRESENCE WITHOUT THE EXPENSIVE CAPITAL AND OPERATING FUND COMMITMENT FOR A STAND-ALONE MEDICAL CENTER.
- ESSENTIALLY SATISFIES THE VA-DOCUMENTED NEED FOR A VETERAN INPATIENT FACILITY IN SOUTHERN NEVADA (ONE OF ONLY TWO LARGE METROPOLITAN AREAS IN THE CONTINENTAL U.S. WITH NO VA HOSPITAL WITHIN EITHER A FOUR-HOUR DRIVE OR 240 MILES).
- EXTREMELY COST EFFECTIVE, AS COMPARED TO ANY ALTERNATIVE OR TO THE PRESENT SYSTEM OF USING A COMBINATION OF CHAMPUS (FOR THE AIR FORCE), CONTRACT HOSPITAL (FOR THE VA) AND OUT-OF-AREA REFERRALS TO APPROPRIATE LARGER VA OR AIR FORCE MEDICAL CENTERS.
- MORE READILY JUSTIFIES THE PROVISION OF SPECIALIZED SERVICES AND HIGH-TECH SYSTEMS WHICH WOULD NOT BE JUSTIFIED BY AIR FORCE OR VA WORKLOAD ALONE.

WITH AN EXPECTED 85,000 TO 100,000 VETERANS IN THE LAS VEGAS CATCHMENT AREA WHO WILL BE MEDICALLY UNSERVED OR UNDERSERVED BY 1990 AND WITH THE VERY HIGH COST OF NON-FEDERAL HOSPITAL CARE IN LAS VEGAS, IT IS BELIEVED THAT THIS IS AN OPPORTUNITY FOR THE VA AND AIR FORCE TO BE "ON THE CUTTING EDGE" IN GOVERNMENTAL HEALTH CARE SHARING.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

CHAIRMAN MONTGOMERY TO VETERANS' ADMINISTRATION

**Office of the
Administrator
of Veterans Affairs**

Washington DC 20420

**Veterans
Administration**

In Reply Refer To:

AUG 18 1986

Honorable G. V. (Sonny) Montgomery
Chairman, Committee on
Veterans' Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed please find our responses to the questions you submitted on behalf of Representative J. Roy Rowland and yourself following the Committee's hearing held on June 26, 1986, regarding VA/DoD sharing. I appreciate the opportunity to provide this additional information for the record.

Sincerely,

THOMAS K. TURNAGE
Administrator

Enclosure

"America is #1—Thanks to our Veterans"

CONGRESSMAN (SONNY) MONTGOMERY

Question: 1. What progress has been made with regard to shared purchase of advanced medical technology under the VA/DoD Sharing Act?

Answer: The VA and DoD are involved in the shared purchase of advanced medical technology. In FY 1985, the VA purchased 18 CT scanners at a bulk rate. The Air Force bought three of these scanners from the VA at half the list price. In FY 1986, the VA is purchasing 20 CT scanners, five of which will go to the Air Force and two to the Navy at considerable savings to the military.

In addition, the VA and DoD are discussing a similar bulk purchasing arrangement of Magnetic Resonance Imaging (MRI) equipment. The military utilization of MRIs already in place at VAMCs is also being discussed.

VAMCs that have recently obtained lithotripters are exploring sharing possibilities with military hospitals. In several cases the negotiating facilities are hundreds of miles apart.

DoD was prohibited from participating in the $10 million advanced medical technology program in FY 1986 by Congressional appropriations language. Sharing of advanced medical technology between the two agencies could be encouraged in the FY 1987 appropriations process by allowing DoD to participate in any special earmarked sharing appropriation.

Question: 2. I know VA and DoD alternate chairing of the health resources sharing committee. What other formal opportunities exist for mutual planning between the VA and DoD?

Answer: Besides the VA/DoD Sharing Committee, Dr. Ditzler regularly attends the meetings of the Defense Health Council, where planning issues are frequently discussed. In addition, the Department of Medicine and Surgery and the Defense Facilities Agency are coordinating hospital planning activities.

Question: 3a. Have the providing facilities' headquarters or next higher commands adhered to the mandate to reimburse the providing facilities as an incentive for inter-agency reimbursement?

Answer: VAMCs are reimbursed for services provided to DoD in conformance with the VA/DoD Sharing Law.

Question: 3b. Have the providing facilities' headquarters or next higher commands reduced the providing facilities' budget or resource allocation as a result of sharing agreement reimbursement?

Answer: No.

Question: 4a. To what extent, if any, has establishment of reimbursement rates been a barrier to implementing effective sharing agreements?

Answer: VA Central Office has not established reimbursement rates for VAMCs. The VA/DoD Sharing Law mandates local rates.

Question: 4b. What type of problems, if any have been identified in the reimbursement and rate setting process? How have you resolved the problems, if any?

Answer: The most common problem has been confusion on what constitutes "actual costs." This problem is under study.

Question: 4c. Have any agency medical facilities or higher authorities proposed or used full costs or standard interagency reimbursement rates that do not allow for appropriate local flexibility as envisioned in the law? What has been the resolution of any such situations?

Answer: Occasionally, a VAMC will submit a proposal listing what appears to be inter-agency rates although they are never identified as such. As long as the VAMC is satisfied that it is being reimbursed adequately and the reviewers in DM&S's Clinical Affairs Office are satisfied that the charge is reasonable the amounts have not been questioned. No VAMCs or higher authorities have proposed using full costs. All rates have been set locally.

Question: 5a. Since the 1983 workshops what additional steps have you taken to monitor and promote P.L. 97-174?

Answer: Five newsletters have been published and distributed to the field. The newsletters describe innovative agreements negotiated.

A VA/DoD sharing exhibit booth was set up at the 1985 Association of Military Surgeons Convention Another booth is planned for the group's 1986 convention.

Letters clarifying reimbursement procedures, encouraging education and training agreements, promoting local sharing of newly funded medical equipment, and targeting local opportunities for sharing have also been sent to the field. Regional Medical Planning Boards are receiving briefing on opportunities for VA/DoD sharing. The VA/DoD sharing law also has been the subject of frequent media attention.

Question: 5b. What is the organizational makeup and staffing of VA and DoD units whose mission it is to monitor and promote P.L. 97-174?

Answer: The Emergency Management and Resource Sharing Service (10B/EMS) is the focal point for sharing activities. One full time program analyst (GS-13) is assigned to VA/DoD sharing. DM&S regional offices play an important role in promoting sharing, especially in joint venture hospital construction planning. Both the Resource Sharing Service and the DM&S regional offices report to the Director for Operations (10B).

Question: 5c. What have been the results of the assigned VA and DoD units in their monitoring and promotion of P.L. 97-174?

Answer: The results are clear. Some 100 VAMCs have negotiated agreements with their military counterparts. All VAMCs within 25 miles of a military facility have at least one agreement. Within a 50 mile radius only five VAMCs have not signed agreements.

Joint venture hospital construction planning is also underway at several sites. Taxpayers will save millions of dollars, and veterans will gain greater access to medical care because of these joint ventures.

Question: 5d. What future plans do you have for monitoring and promotion of P.L. 97-174 to ensure that the potential for maximum interagency sharing of medical resources is achieved?

Answer: More newsletters, a permanent exhibition booth for conventions, and a site by site review of potential joint ventures. Regional and Medical District Planning Boards (where appropriate) will receive briefings on opportunities.

Question: 6a. What do you see as the major strengths and weaknesses of P.L. 97-174?

Answer: The major strengths of the program are the emphasis on local reimbursement rates, reimbursement for services returned to the local facilities, and the law's broad definition of what can be shared. The major weakness is the inability (legally) to treat all DoD beneficiaries.

Question: 6b. In your opinion, what have been the problems and successes that you see from the sharing program's operation since May 2, 1982. What do you see for the future of the program?

Answer: The major success has been the grassroots support of the program. The major problems are confusion over "actual costs" of reimbursement and inability to treat all classes of DoD beneficiaries.

Question: 7. You mentioned in your testimony that there are Sharing agreements for education and training of DoD medical corps reserve units in VA facilities. What other agreements are planned or active in the area of graduate medical education or training under the VA/DoD Sharing Act?

Answer: VAMCs accept residents from DoD for special training in orthopedics, otolaryngology and other services. We also sent our residents for special training at military medical facilities. Military physicians on active duty also receive training at VAMCs on an individual basis. In addition, military nursing personnel at all levels avail themselves of training opportunities at many VAMCs.

Question: 8. There is a multiple responsibility in DoD, VA and the National Disaster Medical System for war and disaster contingency planning. What is the current status of establishing a lead agency for the National Disaster Medical System?

Answer: Leadership of the National Disaster Medical System is unclear at this time.

Question: 9. How does the VA/DoD contingency hospital system relate to the National Disaster Medical System (NDMS)? To the Civilian Military Contingency Hospital System (CMCHS)?

Answer: In a military contingency, DoD and VA beds will be used until the capabilities are saturated. At that time casualties will begin flowing to non-Federal civilian hospital beds signed up in the National Disaster Medical System. In a civil disaster, non-Federal civilian beds would be used first with DoD and VA beds being used, if necessary. The CMCHS was fully converted to NDMS as of December 31, 1985.

Question: 10. Do you have any VA personnel assigned to Armed Services Medical Regulating Office (ASMRO)?

Answer: A liaison is assigned to ASMRO for exercises and emergencies. If our FY 87 budget proposal is approved, one of the NDMS FTE will be used to assign a full-time VA employee to ASMRO.

Question: 10b. and 10c. What is the plan for communications between the DOD facilities or offices such as the Armed Services Medical Regulating Office (ASMR) and the VA hospitals? Don't you think a computer link between the DoD and VA would be a lot more reliable?

Answer: At the present time communications are by normal telephone and TWX capability. Plans are to explore a computer link-up to the Defense Medical Regulating Information System (DMRIS) at each of our facilities and to our Federal Coordinating Centers.

Question: 10d. Have you exercised the communications plan? If so, how did it go?

Answer: Testing of secure communications during "Exercise Present ARMS '86" was cumbersome and less than satisfactory. No VAMCs are able to receive or transmit classified data directly. Arrangements must be made with other agencies, i.e., FBI, National Guard, Reserve, or active military installations. A courier system with the Department of Justice was instituted. Once permission was granted to transmit in the clear, normal telephone and TWX capabilities were used and reporting was excellent. A secure telephone system with voice and data transmit-receive capabilities are being planned for our Federal coordinating centers and regional directors offices.

HON. J. ROY ROWLAND TO VETERANS' ADMINISTRATION

CONGRESSMAN ROWLAND

Question: 1. What is the potential impact of the CHAMPUS Reform initiative on utilization of DoD and VA facilities and what might this mean in terms of the sharing agreements that have been signed or may be in planning stages?

Answer: The VA's role has not yet been defined in the CHAMPUS Reform initiative. We are thus uncertain as to its possible impact on the utilization of DoD and VA facilities. The VA is willing to assist the Department of Defense in arriving at details of the CHAMPUS initiative that would affect VAMCs.

Question: 2. What effect will Medicare reduced funding for graduate medical education, with a possible decline in the number of trainees, and DoD's restriction in the numbers and types of residency positions, have on the VA's graduate medical education programs?

Answer: Neither will have a direct effect on the VA graduate medical education programs. The Medicare change will reduce funding of residents beyond five years. The VA will be able to support those residents in fields required by VA patients and should result in care by residents in the advanced phase of their education. Both should have a positive influence. The DoD changes are not finalized, but will effect mostly the care of dependents (primarily in pediatrics and obstetrics) and should have little effect on the VA.

CHAIRMAN MONTGOMERY TO DEPARTMENT OF DEFENSE

QUESTIONS FOR THE RECORD

House Veterans' Affairs Committee

Question: What progress has been made with regard to shared purchase of advanced medical technology under the VA/DoD Sharing Act?

Answer: The sharing of advanced medical technology and of expensive ancillary services occurs much more frequently than the shared purchase of these items and services. Frequently, our small medical facilities, whose workload cannot justify the purchase, or even the shared purchase, of extremely expensive technology and services, negotiate a cost-effective agreement with a VA Medical Center. This occurs most frequently in the areas of radiology and pathology.

Discussions have been conducted concerning the shared purchase or shared utilization of lithotripters and Magnetic Resonance Imaging (MRI) equipment. There have been savings in the joint purchase and use of CT scanners.

The current shared procurement program between the DoD, VA and the Public Health Service is being expanded to include contracting for medical equipment. The Interagency Medical Procurement Management Committee (IMPMC) approved this initiative in December 1985. In FY 1987, 24 families of medical equipment items will be procured under the centralized procurement of medical equipment program.

Question: I know VA and DoD alternate chairing of the health resources sharing committee. What other formal opportunities exist for mutual planning between the VA and DoD?

Answer: A liaison has recently been established between the Defense Medical Facilities Office (DMFO) and the VA's Department of Medicine and Surgery for coordination of hospital construction planning. I have invited Dr. Ditzler to attend our monthly Defense Health Council, attended also by the Surgeons General or their representatives and by my own key staff. OASD(HA) has initiated a quarterly joint service meeting attended by representatives from the Surgeons General and by the VA. The National Disaster Medical System (NDMS) provides additional opportunities for mutual planning support.

Question: Please provide the Subcommittee with the number of sharing agreements for each branch of service under the VA/DoD Sharing Act. Also, please provide the number of installations involved in the agreements for each branch of service.

Answer: Attached are listings of the VA sharing agreements from each of the Services. These listings were prepared prior to the hearing held by your committee on 26 June 86. The number of installations having sharing agreements by service are - Army 25, Navy 14, and Air Force 42. The number of agreements are estimated to be Army 60, Navy 30, and Air Force 71. The numbers of individual agreements are an estimate. The exact number of agreements is not critical as some facilities include many services under one agreement while others negotiate separate agreements for various medical services. We are working with the Services and the VA to develop improved and more meaningful reporting procedures for agreements.

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AF/VA SHARING ARRANGEMENTS

	USAF MTF	VA MEDICAL CENTER	USAF MTF PROVIDES	USAF MTF RECEIVES
1.	Arnold AFS (Eglin)	VAMC Murfreesboro		Inpt. Outpt. Diagnostic Procedures
2.	Barksdale	VAMC Shreveport	Blood Products, Anesthesiology	Lab. Radiology
3.	Carswell	VAMC Dallas	Inpt. Outpt. Lab	Lab, Cardiac Cath, Open Heart Surg
4.	Chanute	VAMC Danville	ENT, OB/GYN, Pediatric Inpt and Outpt	Nuclear Med. Audiology
5.	Charleston	VAMC Charleston		Radiographic Procedures, Radiology Svcs
6	avid Grant	VAMC Martinez	Radiotherapy	
7.	Davis-Monthan	VAMC Tucson		Lab, OB/GYN
8.	Edwards	Loma Linda	Lab, Pharm, X-ray, Casting, EKG, Blood, Outpt-IM-Prim Care-Gen Surg, Optometry, ER, Acute Care, Inpatient Care	Pulmonary, Gastroenterology, Allergy & Immunology, Treadmill, Colonoscopy, EKG, Brain Scan, Liver/Spleen Scan, Thyroid Scan/Uptake, Stress/Rest
9.	Elmendorf	VA Clinic Anchorage	Designated VA Beds, Inpt, Outpt, Dental	VA Mini-Computer
10.	Ellsworth	VAMC Fort Meade	OB-GYN, Oral Surg, Ortho, Gen Surg, IM, Anes, Family Prac, PT, Dental, Pharm, Radiology, Lab, Biomedical Svcs	Lab, Cardiac Lab, EEG, Pulmonary Func, Radiology, Dental Lab, Psych Inpt, Biomedical Svcs

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AF/VA SHARING ARRANGEMENTS

USAF MTF	VA MEDICAL CENTER	USAF MTF PROVIDES	USAF MTF RECEIVES
Ellsworth	VAMC Hot Springs	GYN, Dental, Lab, Biomed, Environmental, Space	Audiology, Dental, Engineering, Nuclear Med, Lab, Podiatry, Surg, Speech Path, Laundry
11. England	VAMC Alexandria	Lab, Radiology, Dental	Nuclear Med, Echocardiograms, Pulmonary, Vascular, Urology, Dietetic Consults, Lab
12. Ehrling Bergquist	VAMC Omaha	Outpt, Inpt	Nuclear Med, Inpt Psych, Neurology, Gastroenterology, Laundry
13. Fairchild	VAMC Spokane	Ophth, GYN Surg (Inpt & Outpt), Lab & OR (Emergency Use), Sterilizer, Refractory Eye Exams	Nuc Med, Emer Svcs, Use of Angiographic X-Ray Equip, GE 800 MA X-Ray, Dental X-Ray, Laundry, Sterilizer, Lab & OR (Emer Use)
14. F. E. Warren	VAMC Cheyenne		PT, Nuclear Med, Pharmacy, Dietetic, +ADP Radiology, Nurse Anesthetist, Surg Supplies, Lab, Inpt Med, ICU, Surg Svcs
15. Grand Forks	VAMC Fargo	Phys Exams, Dental Care	Outpt, Dental Care for Mbrs of 119th Fighter Interceptor Group at Fargo

AF/VA SHARING ARRANGEMENTS

USAF MTF	VA MEDICAL CENTER	USAF MTF PROVIDES	USAF MTF RECEIVES
16. Griffiss	VAMC Syracuse		Pathology
17. Grissom	VAMC Marion	Internal Med, Cardiology	Podiatry, Radiology, Library, Audiology, Speech Pathology
Grissom	VAMC Battlecreek		Dental Care for Personnel Assgn to ANG Field
18 Hanscom	VAMC Bedford		Outpt Psych, Lab
Hanscom	VAMC Manchester		Inpt - Surg, Med, Psych, Nursing Home, Outpt Pharm, Dental
19. Hill	VAMC Salt Lake City		Nuc Med
20. Keesler	VAMC Biloxi	CT, Genetics, Radiation Therapy, Educational Programs, Angiograms, Echocardio, Dermatology, Dilatation, Oncology, Surgery, Cytogenetics, Chemotherapy	Library, Gen Surg
21. Kirtland	VAMC Albuquerque		Fluoroscopy, Polytomes, Angiography, Ultrasound, Interventionals
22 Langley	VAMC Hampton	Mini-Resident Critical Care Clinical Program for RNs, Frozen Sections, Cytologies, Outpt	Frozen Sections, Cytologies, Outpt Neuro, Lab

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AF/VA SHARING ARRANGEMENTS

USAF MTF	VA MEDICAL CENTER	USAF MTF PROVIDES	USAF MTF RECEIVES
23. Little Rock	VAMC Little Rock		Outpt, Inpt
24. Loring	VA Med & Rgn Office	Gen Med, Gen Surg, GYN, Internal Med, Outpt Psych, Compensation/Pension Exams, Misc Inpt	
25. Luke	VAMC Phoenix		Nuclear Med, Use of Argon Laser Photo-coagulator
26. MacDill	VAMC Tampa		Cardiology, Nuclear Med, Colonoscopy, Med Supply
alcolm Grow	VAMC Washington, DC	Transportation of VA A/E Pts	Dietetic Intern Trng
28. Malmstrom	VAMC Fort Harrison		Inpt Care of AD During Contingency Operations
29. Maxwell	VAMC Montgomery	Pulmonary Functions, Reads and Interprets EMG Tapes	2D Echo Cardiogram Read and Interpret, Use of Central Sterile Equip and Fac
30. McConnell	VAMC Topeka		Inpt, Outpt, Ancillary Svcs for Members of 190 Air Refuel Group (ANG) While on Active Duty and Eligible for Care
cGuire	VA System	Blood (Armed Services Whole Blood Processing Laboratory)	

AF/VA SHARING ARRANGEMENTS

USAF MTF	VA MEDICAL CENTER	USAF MTF PROVIDES	USAF MTF RECEIVES
32. Minot	VAMC Fargo	Designated VA Beds, Outpt	
33. Mt Home	VAMC Boise		Lab, Nuclear Med, Inpt and Outpt Endoscopic & Ultrasound, misc Ancillary, Outpt, Inpt
34. Nellis	VA Clinic Las Vegas		Radiology, Ultra Sound, Visual Field Exam w/ interpretation
35. Peterson	VAMC Ft Lyon		Inpt, Outpt, Ancillary (Personnel at La Junta)
36. Reese	VA Clinic Lubbock	Inpt, Outpt, Lab, Equip Repair, Ambulance Svc	Lab, Outpt, Diagnostic Testing
37. Robbins	VAMC Dublin	Audiology, Blood Svc, OB-GYN	Lab, Medical Record Svcs, Radiology
38. Tinker	VAMC Oklahoma City		Nuc Med
Volk Field (ANG)	VAMC Toman	Motor Vehicle Equip	Laundry Svcs, Med, Outpt Alcohol, Drug Abuse, Psych, EEG, EKG, RMS Therapy, Chaplain Svcs, Audiometry Testing
39. Whiteman	VAMC Kansas City	OB/GYN	Lab, Radiology, CT, Nuclear Med, Outpt, Ancillary, Inpt - Med, Surg, Psych, MICU/CCU, SICU

AF/VA SHARING ARRANGEMENTS

	USAF MTF	VA MEDICAL CENTER	USAF MTF PROVIDES	USAF MTF RECEIVES
40.	Wilford Hall	VAMC San Antonio	Blood, Blood Supplies	5 FTEE, Blood Bags, Trans
41.	Williams	VAMC Phoenix		Nuclear Med
42.	Wright-Patterson	VAMC Chillicothe	CT, Radiation Therapy	
	Wright-Patterson	VAMC Dayton	CT, Radiation Therapy	Misc Ancillary
	Wright-Patterson	VAMC Lebanon		PT Training

COVER SHEETS FOR ALL SHARING AGREEMENTS BETWEEN VA AND NAVAL MTFs

	Expiration Date	Total
1. **NAVHOSP Orlando**		
Stress Testing Holter Exam Recording Echocardiograph Testing Orthopedic Consultation and Minor Treatment Inpatient Social Work Liaison Service Laboratory Service Alcohol Rehabilitation Service GYN Outpatient Examinations Acute Medical Admission Acute Abdominal Surgery	2/86*	10
2. **NAVHOSP San Diego**		
Research and Training Programs	4/85*	1
3. **NAVHOSP Millington**		
Inpatient Care and Outpatient Care Diagnostic Procedures	FY-89	1

* Currently in negotiation

COVER SHEETS FOR ALL SHARING AGREEMENTS BETWEEN VA AND NAVAL MTFs

	Expiration Date	Total
4. NAVHOSP Charleston		
Laboratory Tests, Electron Microscope, Cardiac Catheterization, Inpatient Surgical, and Medical Intensive Care Unit	8/86	1
5. NAVHOSP Jacksonville		
Medical Inpatient and Outpatient Care in Various Medical Specialties	9/88	1
6. NAVHOSP Roosevelt Roads		
Inpatient and Outpatient Medical Services	9/85*	1
7. NAVHOSP Long Beach		
Oral Surgeons and General Practice Dental Residents	12/86	3
Services and Tests for Blood	9/86	
Air Quality Reports	10/86	

* Currently in negotiation

COVER SHEETS FOR ALL SHARING AGREEMENTS BETWEEN VA AND NAVAL MTFs

	Expiration Date	Total
8. NAVHOSP Bethesda		
Diagnostic Laboratory Testing	12/86	1
9. NAVMEDCLINIC New Orleans		
Surgical Procedures and Related Services	3/86	1
10. NSHS Bethesda		
Training of Electroencophalographic Technician Students	1/91	1
11. NAVMEDCLINIC Portsmouth		
General Medical and Surgical Outpatient Visits	9/86	1
12. NAVHOSP Philadelphia		
CT Scans	9/91	2
GYN Services	9/91	

COVER SHEETS FOR ALL SHARING AGREEMENTS BETWEEN VA AND NAVAL MTFs

	Expiration Date	Total
13. **NAVHOSP Guam**		
Internal Medicine, Dermatology, Opthalmology, General Surgery, Alcolhol Rehabilitation Services, Laboratory, Pharmacy, Radiology	12/86	2
Outpatient Dental Treatment	7/86	
14. **NAVHOSP Great Lakes**		
Noninvasive Vascular Studies	3/85*	4
Therapeutic Radiology Quality Assurance Program	2/86	
Laundry	12/87	
Speech/Audiology Evaluation Treatment	6/85*	
Grand Total of Agreements		30

* Currently in negotiation

VA/DOD SHARING AGREEMENTS
Participation as of 16 June 1986

HSC AGREEMENT NUMBER	ACTIVITY (ACTIVITY AGREEMENT NUMBER)	FROM	TO	VA PROVIDES	MEDCEN/MEDDAC PROVIDES	REQUESTED DATE	APPROVED DATE	REMARKS
3-84	Ft Campbell, KY & VAMC, Nashville, TN (W45RBK-84031-626-001)	27 Jan 84	27 Jan 89	Inpatient/Outpatient Care, Diag Procedures	Inpatient/Outpatient Orthopedic Appliances, Dental Visits	3 Feb 84	16 Mar 84	
6-84	Ft Bragg, NC & VAMC, Fayetteville, NC (W36QX9-84016-015)	1 Jun 84	30 Sep 86	Pulmonary Flow Loop Test, Blood Support, Speech Therapy, Outpnt Rehab	Morgue, blood, CT, Mammography, Speech Therapy, EMS Ambulance Service, Emerg, GTN	13 Apr 84	10 May 84	
6-84A		Dec 84	30 Sep 86			5 Nov 84	7 Dec 84	Amendment
6-84A		Aug 85	30 Sep 86			19 Jul 85	20 Aug 85	Amendment
8-84	Ft Knox, KY MEDDAC & VAMC, Louisville, KY (603-1)	Jun 84	30 Sep 86	Tomography, Vascular Imaging, Cardiac Catherization, Inpnt Care Operating Room	Blood, Dental visits Optometry visits, GTN	20 Apr 84	11 Jun 84	Automatically approved due to time lapse over 45 days
8-84A		May 85	30 Sep 86			5 Apr 85	20 May 85	Amendment
8-84A		Sep 85	30 Sep 86			9 Aug 85	16 Sep 85	Amendment (Supersedes previous A)
9-84	MAMC & VAMC, Seattle, WA	1 Aug 84	30 Sep 87	Neurosurgical Services		29 Jun 84	10 Jul 84	
9-84A		Jun 85	30 Sep 87			16 May 85	20 Jun 85	Amendment
9-84A		Dec 85	30 Sep 87			21 Nov 85	6 Dec 85	Amendment

VA/DOD SHARING AGREEMENTS
Participation as of 16 June 1986

HSC AGREEMENT NUMBER	ACTIVITY (ACTIVITY AGREEMENT NUMBER)	FROM	TO	VA PROVIDES	MEDCEN/MEDDAC PROVIDES	REQUESTED DATE	APPROVED DATE	REMARKS
10-84	Ft Ben Harrison, HACH & VAMC, Indianapolis, IN (1-84)	1 Jul 84	30 Jun 89	Inpatient/Outpatient Services	Inpatient/Outpatient Services	12 Jul 84	23 Jul 84	
11-84	Ft Jackson, SC & VAMC, Columbia, SC (W37HFR-84257-006)	Jul 84	Sep 90	CAT Svcs, Angiograms, Consultations, Medical and Dental Supplies & Equipment	Podiatry Consultants	13 Jul 84	22 Jul 84	
14-84	Ft Knox, KY MEDDAC & VA Outpnt Clinic, Columbus, OH	Oct 84	Sep 86	Dental Treatment		7 Aug 84	22 Aug 84	
15-84	Ft Bragg, NC MEDDAC & VAMC, Durham, NC (W36QX9-84214-003)	Aug 84	Sep 86	Neurosurgery, Vascular Surgery, Thoracis Surg, Acute Radiation Therapy, Serum Tests		10 Aug 84	24 Aug 84	
15-84A		Nov 85	Sep 86			11 Oct 85	25 Nov 85	Amendment
16-84	Ft Wainwright, AK MEDDAC & VAMC, Anchorage, AK	Sep 84	Sep 87	Medical Officer, MOD Back-up	Inpatient/Outpatient Services	10 Aug 84	5 Sep 84	
21-84	Ft Leonard Wood, MO MEDDAC & VAMC, Tomah, WI	Oct 84	Jan 89	Psychiatric Services Medical Equipment Repair Services		31 Aug 84	18 Oct 84	
21-84A		Aug 85	Jan 89			17 Jul 85	6 Aug 85	Amendment

VA/DOD SHARING AGREEMENTS
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HSC AGREEMENT NUMBER	ACTIVITY (ACTIVITY AGREEMENT NUMBER)	FROM	TO	VA PROVIDES	MEDCEN/MEDDAC PROVIDES	REQUESTED DATE	APPROVED DATE	REMARKS
23-84	DDEAMC & VAMC, Augusta, GA (W33BWP-84256-015)	Jan 85	Sep 89	Bone, lung, liver biopsies, CT scans, etc.	Bone, lung, liver biopsies, CT scans, etc.	6 Dec 84	27 Dec 84	
23-84A		Aug 85	Sep 89	Added Appendices C & D		19 Jul 85	14 Aug 85	Amendment
25-85	Ft McClellan, AL DENTAC & VAMC, Birmingham, AL (85/DOD/201)	Mar 85	30 Sep 88	Dental Services	Dental Services	4 Mar 85	25 Mar 85	
26-85	Ft Knox, KY MEDDAC & VAMC, Lexington, KY (365303-85004-001)	Apr 85	Sep 86	X-Ray Film Interpretation		7 Mar 85	5 Apr 85	
27-85	DDEAMC & VAMC, Augusta, GA (V509(90)S-85001)	May 85		Open heart surgery		7 Mar 85	10 Apr 85	
28-85	Ft Devens & VAMC, Syracuse, NY	Jul 85	30 Sep 86	Med/Surg Inpatient care, CT scans	Storage space at Ft Drum	8 Apr 85	17 Jul 85	

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RSC AGREEMENT NUMBER	ACTIVITY (ACTIVITY AGREEMENT NUMBER)	FROM	TO	VA PROVIDES	MEDCEN/MEDDAC PROVIDES	REQUESTED DATE	APPROVED DATE	REMARKS
31-85 (1-86)	West Point, MEDDAC & VAMC, Montrose, NY (2-85)	Sep 85	Sep 91	Outpat Diagnostic tests, ER/Outpat Clinic care, OB/GYN clinic care, Inpatient GYN surgery		16 Sep 85	22 Oct 85	Renewal of 7-84 Agrmt
32-85 (2-86)	Ft Leonard Wood, MO & VAMC, Battle Creek, MI	1 Aug 85	1 Aug 91	Dental Care		16 Sep 85	16 Oct 85	
3-86	Ft Devens, MA & VAMC, Syracuse, NY	1 Oct 85	30 Sep 86	Inpatient/Outpatient Care, Diagnostic Procedures		4 Oct 85	27 Nov 85	
4-86	DDEAMC, Ft Buchanan Hlth Clinic & VAMC, San Juan (Two)	Jan 86	Dec 86	Psychiatry, Med & Surg (Inpat), Lab, CT scans, EMS, Rad Survey, CHE & Training (Outpnt)		16 Dec 85	31 Jan 86	Renewal of 30-85 Agrmt
4-86.1	WRAMC & VAMC, Washington, D.C. (W74MYG-85274-804)	1 Oct 85	30 Sep 88	Pacemaker Surveillance	Physician coverage for Pacemaker Center	24 Dec 85	4 Feb 86	
----	Ft Devens & VAMC, North Hampton, MA	DISAPPROVED		Outpatient services Prescription Refills		13 Jan 86	---	DISAPPROVED

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HSC AGREEMENT NUMBER	ACTIVITY (ACTIVITY AGREEMENT NUMBER)	FROM	TO	VA PROVIDES	MEDCEN/MEDDAC PROVIDES	REQUESTED DATE	APPROVED DATE	REMARKS
5-86	MAMC, WA & VAMC, American Lake	1 Oct 85	30 Sep 88	Phys svcs (vasular surg, Urology, Infectious Dis Consults)	Outpatient consults, Diag Radiology, Radiation Ther, Blood Bank, Laboratory	31 Mar 86	21 Apr 86	Supersedes Agrmt 22-84
—	TAMC & VAMC, Honolulu, HI (85/VA/101)	Pending Changes		Suppl Staff Support		22 Jan 86		5 Mar 86 Returned for changes prior to approval
6-86	Ft Hood, TX-Darnall ACH & Olin E. Teague Veteran's Ctr (V674P-1304)	1 Jun 86	31 May 87	Inpatient Psychiatry Serv		9 Jun 86		Pending Appr
7-86	Ft Hood, TX-Darnall ACH & Olin E. Teague Veteran's Ctr (V674P-1246)	1 Oct 85	30 Sep 86		Contaminated Waste Disposal	10 Jun 86		Pending Appr

Question: Public Law 97-174 provides authority in the case of DoD for the commander of a medical facility providing a service to VA facility to directly receive reimbursement funds for the service. Do DoD medical facility commanders receive such funds?

Answer: Army answer: Since reimbursements are received locally, it is anticipated that the MTF or MEDCEN receives the reimbursement. Navy answer: Reimbursements are processed via the regional commander who maintains responsibility for the financial integrity of all MTFs within the region. Air Force answer: Yes, the facility which enters into the agreement with the VA receives the reimbursement.

Question: Have the providing facilities' headquarters or next higher commands adhered to the mandate to reimburse the providing facilities as an incentive to interagency sharing?

Answer: Reimbursements are negotiated locally between the VA and the MTFs. Higher headquarters are not involved except for final approval of sharing agreements.

Question: To what extent, if any, has establishment of reimbursement rates been a barrier to implementing effective sharing agreements?

Answer: Sharing agreements are negotiated locally. Rates have not been a barrier in the implementation of agreements. Should the rates charged by a VA facility be higher than can be obtained elsewhere, a sharing agreement would not be finalized.

Question: Do you have a policy concerning sharing of Automatic Data Processing (or ADP) resources with the VA? If so, what is it? How does your policy account for the critical need for rapid communication between VA and DoD under the emergency operations or wartime?

Answer: The operating policy of the OASD(HA) and its field activity, the Defense Medical Systems Support Center (DMSSC), is that automation and communications support will be shared in cases where it is found to be mission essential. Accordingly, the DMSSC has involved the VA in working groups for those systems which have contingency and mobilization roles. The Defense Medical Regulating Information System (DMRIS), which supports the regulation and movement of patients both in peacetime and in contingency situations, is scheduled to be tested in a VA facility during FY 87. The VA also participates in the DMSSC Communications Interface Work Group which defines communications requirements for the DMSSC information architecture.

Question: Give us your views on amending legislation to permit CHAMPUS to reimburse VA hospitals under P.L. 97-174 sharing agreements for care of military retirees.

Answer: With care of military retirees at VA hospitals already permitted under sharing agreements, the question of CHAMPUS reimbursement centers on the most appropriate source of the funds to be used. While there is no official Administration position on the question, it is my personal view that permitting CHAMPUS reimbursement could have negative effects. It could blur the clean lines of responsibility in sharing agreements by removing any financial liability for military treatment facility referral decisions and transferring that liability to CHAMPUS. If the legislative change would require retirees to use VA hospitals when space is available, it would be inconsistent with prior law changes, at the behest of beneficiaries, that prohibited CHAMPUS from denying payment for civilian care simply because the beneficiary is entitled to VA care. If VA care when space is available is not a requirement but an option, it is doubted that the demonstrated beneficiary perceptions would result in optimum use of VA facilities. To overcome this demonstrated reluctance, reduced or no beneficiary cost sharing for care provided in a VA hospital could be legislated, but this would depart from all other CHAMPUS payment determination procedures and add administrative requirements and costs. Finally, there would be a question about CHAMPUS applying its standard medical necessity and appropriateness criteria and benefit limits to care provided by another government agency. What happens if care is denied?

These complexities in the face of our major initiatives to simplify the military health services system raise questions that lead to my personal reluctance to support CHAMPUS payment for VA care. Instead, the sharing agreements potentially could accomplish much the same result without the complications and without changing the implicit different purposes in the separate lines of funding CHAMPUS to pay for civilian care and funding military facilities for care that they provide or arrange.

Question: What steps will be taken to ensure that the restructuring of CHAMPUS now being contemplated does not discourage DoD/VA sharing?

Answer: Mr. Chairman, I do not know whether current law might prevent the VA from participating. Assuming that there is no legal obstacle, then certainly the VA could be a part of Project IMPRINT - the CHAMPUS Reform Initiative.

In the simplest possible terms, DoD plans, through the competitive procurement process, to make three contractors responsible for providing and paying for all care that is provided outside our direct care system for dependents, retirees, and survivors.

To do this, these three contractors will have to set up networks of individual and institutional medical providers with whom they will probably have a contractor/subcontractor relationship. It seems plausible that VA facilities could very easily affiliate with one of the prime contractors to be part of the contractor's preferred provider network if the law allows such an arrangement.

A very important consideration, however, Mr. Chairman, is one which I know you would share: the impact of any such move upon the VA's beneficiaries would have to be very carefully studied by the VA and by the Congress to be certain that such a move would not adversely affect our veterans.

My office has just issued the draft request for proposals for the CHAMPUS Reform Initiative, seeking comments and suggestions. I personally sent Dr. Ditzler a copy and look forward to his input.

Question: A recent report by a DoD contractor suggested that both the government and military retirees may be able to save money if a portion of CHAMPUS workload were shifted to VA medical centers. What is your view of this?

Answer: In the report mentioned, the contractor used average government costs under CHAMPUS for retirees in the area selected for comparison, Fayetteville, North Carolina. The report also noted that 63% of retirees have other insurance coverage. When retirees with and without other insurance coverage are considered separately, the government cost under CHAMPUS for those with other insurance in that area is only about 55% of the VA per diem rate used in the report. That is, while the average is relatively correct and results in an overall DoD savings if the VA per diem rate were paid, VA care for those with other insurance would be disadvantageous to DoD if considered separately. It also could be disadvantageous to the beneficiaries if they pay a portion of the VA rate under the same cost-sharing provisions that apply to civilian care. Most of those with other inpatient insurance have no liability for care payable under CHAMPUS because of how coordination of benefits provisions are applied. While VA was given authority in Public Law 99-272 this year to collect from other insurance coverage for VA care on a phased in basis, collections go to the United States Treasury and are not available to the facility that provided the care to offset its rates in a particular case.

Conversely, DoD costs for retirees without other insurance, based on the Fayetteville VA rates used in the report, could be as low as 38% of costs under CHAMPUS. If beneficiary cost-sharing applies to the VA rate, it also would be a significant advantage to the beneficiary without other insurance.

The maximum DoD financial advantage would be gained if only those retirees without other insurance coverage obtained care in VA facilities when the care is not available at military treatment facilities where preparedness training needs must come first.

The potential for savings with the provisos described is attractive, but the added beneficiary and administrative complications involved in realizing the savings are not. We are attempting through the CHAMPUS Reform Initiative to simplify an already too complex CHAMPUS and military facility interface that creates beneficiary dissatisfactions and concerns.

Question: Would it be desirable for National Guard units to enter into sharing agreements with VA medical facilities as a means of reducing health care costs? Have any been negotiated?

Answer: Yes it would be desirable. In fact, some National Guard units have negotiated training and diagnostic service sharing agreements with the VA.

Question: Since the 1983 workshops, what additional steps have you taken to monitor and promote P.L. 97-174?

Answer: To monitor the program, we have established quarterly meetings with the Services at the OASD(HA) level. Dr. Ditzler and I continue to alternately chair the Health Resources Sharing Committee, which oversees the implementation of Public Law 97 - 174. Our promotional efforts include the publication of a quarterly newsletter to market the program, a large, well-designed exhibit at the annual meeting of the Association of Military Surgeons (AMSUS), and the recent signing of a Memorandum of Understanding (MOU) clarifying reimbursement procedures and the referral process for active duty patients. In addition, I have invited Dr. Ditzler to attend the monthly meeting of the Defense Health Council, where joint-planning issues are often discussed.

Most importantly, the Services should be commended for their creative, innovative and enthusiastic approach to the program. They actively monitor and promote sharing agreements through seminars and through Surgeon General correspondence to the field.

Question: Why is the Army treating the sharing program like any other interservice support agreements?

Answer: At one time the Army staff believed the sharing program required the same documentation, i. e., a Defense Retail Interservice Support Agreement (DD Form 1144), as did other interservice support agreements. The Army no longer requires the DD Form 1144 to be submitted prior to the approval of proposed DoD/VA Sharing Agreements. Hospital commanders are requested to submit the form as soon as possible thereafter. The completed DD Form 1144 is held on file for future audit purposes.

Question: What do you see as the major strengths and weaknesses of P.L. 97-174?

Answer: The major strengths of the law are that it provides for the sharing of resources between the two agencies and that decisions, including reimbursement rates, can be made at the local level. Sharing agreements are easy to complete and, unless disapproval action is taken by the Services, implementation is automatic.

The main weakness of the law is the legal inability of VA facilities to treat all classes of DoD beneficiaries. The General Counsels of each agency have had considerable difficulty interpreting the eligibility of DoD dependents, and there is still some confusion concerning the extent of eligibility of National Guard and Reserve personnel. Also, in Section 3, paragraph (d)(1), the phrase "head of each medical organization" would be preferable to the phrase "head of each medical facility".

Question: In your statement you alluded to legal and administrative stumbling blocks to establish sharing agreements. Please give some examples of these stumbling blocks.

Answer: There was initial resistance from the Services and from various veterans groups to the concept of VA/DoD sharing. There were procedural issues which were resolved by the joint working groups at the time of the initial implementation of the program. For the most part, these initial problems have been resolved.

Question: There is a multiple responsibility in DoD, VA and the National Disaster Medical System for war and disaster contingency planning. What is the current status of establishing a lead agency for the National Disaster Medical System?

Answer: There is a multiple responsibility in DoD, VA, HHS, and FEMA for war and disaster contingency planning. The National Disaster Medical System (NDMS) is a joint venture of these four organizations. The lead agency for wartime medical planning is DoD, while the VA serves as the primary backup to the military medical system. The lead agency for domestic disaster medical planning is HHS. FEMA has overall coordinating responsibility for federal disaster assistance. During an actual activation of NDMS in a time of war, DoD would assume the lead agency responsibility. HHS would be the lead agency during any system activation as a result of a catastrophic disaster within the United States.

These four agencies, in conjunction with numerous other federal, state, and local agencies, organizations, and associations, are working diligently to make NDMS a true national asset.

HON. J. ROY ROWLAND TO DEPARTMENT OF DEFENSE

Question: What is the potential impact of the CHAMPUS Reform Initiative on utilization of DoD and VA facilities and what might this mean in terms of the sharing agreements that have been signed or may be in planning stages?

Answer: The CHAMPUS Reform Initiative is designed to improve the services received from civilian sources of care by our other than active duty beneficiaries. DoD facilities will continue to be utilized to the fullest extent possible. As VA sharing agreements pertain primarily to our active duty personnel and to the sharing of resources, they will not be discouraged by the CHAMPUS Reform Initiative. Thus, I believe the impact on present agreements or those in the planning process will be negligible.

Question: What effect will Medicare reduced funding for Graduate Medical Education, with a possible decline in the number of trainees, and DoD's restriction in the numbers and types of residency positions, have on the VA's Graduate Medical Education Programs?

Answer: I cannot speculate on the implications of the Medicare reduction. Regarding DoD, I see no adverse effects on the VA Graduate Medical Education that will result from the DoD plan to restructure Graduate Medical Education. It is DoD's intent to more closely align its training programs with its requirements for critical wartime specialties. This realignment involves a reduction in the numbers of physicians trained in less critical specialties and maximizing the numbers that are trained in the more critical wartime specialties. While we will reduce the number of peacetime specialists that we train, there should not be any degradation of services provided to DoD beneficiaries.

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